```
                                  POSITIONS
              NAME              TYPE  LENGTH BEG   END                        CONTENTS
       -------------------------  ----  ------ ---------  ----------------------------------------------------------

****   FI Home Health Agency (HHA)  REC    VAR                 Fiscal intermediary Home Health Agency Encrypted
       Claim Record - Encrypted                                Standard View for version I of the NCH.
       Standard View
                                                               The Encrypted Standard View supports the users of
                                                               CMS data and provides the data in "text" ready
                                                               format for easy conversion to ASCII text files.
                                                               This file is also specifically processed to
                                                               perform CMS standard encryption processes for
                                                               identifiable and personal health information
                                                               data fields.

****   FI HHA Claim Fixed          GROUP   238    1   238      Fixed portion of the fiscal intermediary
       Group - Encrypted                                       claim record for the Encrypted Standard
       Standard View                                           View of the Home Health Agency claim record
                                                               for version I of the NCH Nearline File.


   1.  Record Length Count         NUM      5     1    5       The length of the record.

                                                               5 DIGITS UNSIGNED

   2.  Record Number               NUM      9     6    14      A sequentially assigned number for the claims included
                                                               in the file. This number allows the user to link all
                                                               of the records associated with one claim.

   3.  Record Type                 NUM      2    15    16      Type of Record.

                                                               CODES:
                                                               00 = Fixed/Main Group
                                                               01 = Carrier Line Group
                                                               02 = Claim Demonstration ID Group
                                                               03 = Claim Diagnosis Group
                                                               04 = Claim Health PlanID Group
                                                               05 = Claim Occurrence Span Group
                                                               06 = Claim Procedure Group
                                                               07 = Claim Related Condition Group
                                                               08 = Claim Related Occurrence Group
                                                               09 = Claim Value Group
                                                               10 = MCO Period Group
                                                               11 = NCH Edit Group
                                                               12 = NCH Patch Group
                                                               13 = DMERC Line Group
                                                               14 = Revenue Center Group

   4.  Claim Sequence Number       NUM      3    17    19      A counter for records that consist of trailer
                                                               information, such as claim line and revenue center data,
                                                               which can occur multiple times for one claim.

   5.  NCH Claim Type Code         CHAR     2    20    21      The code used to identify the type of claim record being
                                                               processed in NCH.
```

```
                          POSITIONS
         NAME          TYPE  LENGTH BEG   END                         CONTENTS
------------------------ ----  ------ ---------   --------------------------------------------------------------

                                             NOTE1:  During the Version H conversion this field was
                                                     populated with data through-out history (back to
                                                     service year 1991).

                                             NOTE2:  During the Version I conversion this field was
                                                     expanded to include inpatient 'full' encounter
                                                     claims (for service dates after 6/30/97).
                                                     Placeholders for Physician and Outpatient encounters
                                                     (available in NMUD) have also been added.

                                             DB2 ALIAS: NCH_CLM_TYPE_CD
                                             SAS ALIAS: CLM_TYPE
                                             STANDARD ALIAS: UTLHHAI_NCH_CLM_TYPE_CD
                                             SYSTEM ALIAS: LTTYPE
                                             TITLE ALIAS: CLAIM_TYPE

                                             DERIVATION:
                                             FFS CLAIM TYPE CODES DERIVED FROM:
                                               NCH CLM_NEAR_LINE_RIC_CD
                                               NCH PMT_EDIT_RIC_CD
                                               NCH CLM_TRANS_CD
                                               NCH PRVDR_NUM

                                             INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                               (Pre-HDC processing -- AVAILABLE IN NCH)
                                               CLM_MCO_PD_SW
                                               CLM_RLT_COND_CD
                                               MCO_CNTRCT_NUM
                                               MCO_OPTN_CD
                                               MCO_PRD_EFCTV_DT
                                               MCO_PRD_TRMNTN_DT

                                             INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                               (HDC processing -- AVAILABLE IN NMUD)
                                               FI_NUM

                                             INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                             FROM: (HDC processing -- AVAILABLE IN NMUD)
                                               FI_NUM
                                               CLM_FAC_TYPE_CD
                                               CLM_SRVC_CLSFCTN_TYPE_CD
                                               CLM_FREQ_CD
                                             NOTE:  From 7/1/97 to the start of HDC processing(?),
                                             abbreviated inpatient encounter claims are not
                                             available in NCH or NMUD.

                                             PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                               (AVAILABLE IN NMUD)
                                               CARR_NUM
                                               CLM_DEMO_ID_NUM

                                             OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                               (AVAILABLE IN NMUD)
```

```
                                    POSITIONS
                 NAME          TYPE LENGTH BEG  END                              CONTENTS
          -------------------------  ----  ------ ---------  ------------------------------------------------------------
                                                             OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                             DERIVED FROM:  (AVAILABLE IN NMUD)
                                                               FI_NUM
                                                               CLM_FAC_TYPE_CD
                                                               CLM_SRVC_CLSFCTN_TYPE_CD
                                                               CLM_FREQ_CD

                                                             DERIVATION RULES:

                                                               SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                               FOLLOWING CONDITIONS ARE MET:
                                                               1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                               2.   PMT_EDIT_RIC_CD EQUAL 'F'
                                                               3.   CLM_TRANS_CD EQUAL '5'

                                                               SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                               WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                               1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                               2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                               3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                               4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                                                    OR 'Z'

                                                               SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                                                               WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                               1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                               2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                               3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                               4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                                                    OR 'Z'

                                                               SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                                                               WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                               1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                               2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                               3.   CLM_TRANS_CD EQUAL '6'

                                                               SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                                               ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                               THE FOLLOWING CONDITIONS ARE MET:
                                                               1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                               2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                               3.   CLM_TRANS_CD EQUAL '6'
                                                               4.   FI_NUM = 80881

                                                               SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                                               ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                                               1.   FI_NUM = 80881
                                                               2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                                                    CLSFCTN_TYPE_CD = '2', '3' OR '4' &
```

```
                                      POSITIONS
               NAME              TYPE  LENGTH BEG  END                              CONTENTS
-------------------------        ----  ------ ---------   ------------------------------------------------------------
```

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'I'
3.   CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_MCO_PD_SW = '1'
2.   CLM_RLT_COND_CD = '04'
3.   MCO_CNTRCT_NUM
     MCO_OPTN_CD = 'C'
     CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
     MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
     ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
     TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD on DMEPOS table (NOTE: if one or
        more line item(s) match the HCPCS on the
        DMEPOS table).

```
                                                       SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                                       EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                                       CONDITIONS ARE MET:
                                                       1.   CARR_NUM = 80882 AND
                                                       2.   CLM_DEMO_ID_NUM = 38
1           FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                          POSITIONS
              NAME                TYPE  LENGTH BEG  END                         CONTENTS
    -------------------------   ----  ------ --------   -----------------------------------------------------------

                                                       SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                                          CLAIM)
                                                       WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                       1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                       2.   HCPCS_CD not on DMEPOS table

                                                       SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                                       WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                       1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                       2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                             more line item(s) match the HCPCS on the
                                                             DMEPOS table).

                                                       CODES:
                                                         REFER TO: NCH_CLM_TYPE_TB
                                                                   IN THE CODES APPENDIX

                                                       SOURCE:
                                                       NCH


    6. Beneficiary Birth Date       NUM      8    22   29   The beneficiary's date of birth.

                                                       For the ENCRYPTED Standard View of the
                                                       HHA files, the beneficiary's
                                                       date of birth (age) is coded as a range.

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: BENE_BIRTH_DT
                                                       SAS ALIAS: BENE_DOB
                                                       STANDARD ALIAS: BENE_BIRTH_DT
                                                       TITLE ALIAS: BENE_BIRTH_DATE

                                                       EDIT-RULES FOR ENCRYPTED DATA:
                                                       0000000R
                                                       WHERE R HAS ONE OF THE FOLLOWING VALUES.
                                                       0 = Unknown
                                                       1 = <65
                                                       2 = 65 Thru 69
                                                       3 = 70 Thru 74
                                                       4 = 75 Thru 79
                                                       5 = 80 Thru 84
                                                       6 = >84

                                                       SOURCE:
                                                       CWF
```

```
   7. Beneficiary Identification   CHAR    2   30   31  The code identifying the type of relationship between an
      Code                                                 individual and a primary Social Security Administration
                                                          (SSA) beneficiary or a primary Railroad Board (RRB)
                                                          beneficiary.
```

```
                                      POSITIONS
                  NAME            TYPE  LENGTH BEG  END                        CONTENTS
         -------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                          COMMON ALIAS: BIC
                                                          DA3 ALIAS: BENE_IDENT_CODE
                                                          DB2 ALIAS: BENE_IDENT_CD
                                                          SAS ALIAS: BIC
                                                          STANDARD ALIAS: BENE_IDENT_CD
                                                          TITLE ALIAS: BIC

                                                          EDIT-RULES:
                                                          EDB REQUIRED FIELD

                                                          CODES:
                                                            REFER TO: BENE_IDENT_TB
                                                                     IN THE CODES APPENDIX

                                                          SOURCE:
                                                          SSA/RRB

   8. Beneficiary Race Code        CHAR    1   32   32  The race of a beneficiary.

                                                          DA3 ALIAS: RACE_CODE
                                                          DB2 ALIAS: BENE_RACE_CD
                                                          SAS ALIAS: RACE
                                                          STANDARD ALIAS: BENE_RACE_CD
                                                          SYSTEM ALIAS: LTRACE
                                                          TITLE ALIAS: RACE_CD

                                                          CODES:
                                                          0 = Unknown
                                                          1 = White
                                                          2 = Black
                                                          3 = Other
                                                          4 = Asian
                                                          5 = Hispanic
                                                          6 = North American Native

                                                          SOURCE:
                                                          SSA

   9. Beneficiary Residence SSA     CHAR    3   33   35  The SSA standard county code of a beneficiary's residence.
      Standard County Code
                                                          DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
                                                          DB2 ALIAS: BENE_SSA_CNTY_CD
                                                          SAS ALIAS: CNTY_CD
                                                          STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
                                                          TITLE ALIAS: BENE_COUNTY_CD

                                                          EDIT-RULES:
```

OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

```
                                   POSITIONS
             NAME            TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------  ----  ------ --------  --------------------------------------------------------------
```

10. Beneficiary Residence SSA   CHAR   2   36   37   The SSA standard state code of a beneficiary's residence.
    Standard State Code

                                                        DA3 ALIAS: SSA_STANDARD_STATE_CODE
                                                        DB2 ALIAS: BENE_SSA_STATE_CD
                                                        SAS ALIAS: STATE_CD
                                                        STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
                                                        TITLE ALIAS: BENE_STATE_CD

                                                        EDIT-RULES:
                                                        OPTIONAL: MAY BE BLANK

                                                        CODES:
                                                          REFER TO: GEO_SSA_STATE_TB
                                                                    IN THE CODES APPENDIX

                                                        COMMENT:
                                                        1. Used in conjunction with a county code, as
                                                           selection criteria for the determination of
                                                           payment rates for HMO reimbursement.
                                                        2. Concerning individuals directly billable for
                                                           Part B and/or Part A premiums, this element
                                                           is used to determine if the beneficiary
                                                           will receive a bill in English or Spanish.
                                                        3. Also used for special studies.

                                                        SOURCE:
                                                        SSA/EDB

11. Beneficiary Sex   CHAR   1   38   38   The sex of a beneficiary.
    Identification Code

                                                        COMMON ALIAS: SEX_CD
                                                        DA3 ALIAS: SEX_CODE
                                                        DB2 ALIAS: BENE_SEX_IDENT_CD
                                                        SAS ALIAS: SEX
                                                        STANDARD ALIAS: BENE_SEX_IDENT_CD
                                                        SYSTEM ALIAS: LTSEX
                                                        TITLE ALIAS: SEX_CD

                                                        EDIT-RULES:
                                                        REQUIRED FIELD

                                                        CODES:
                                                        1 = Male
                                                        2 = Female
                                                        0 = Unknown

                                                        SOURCE:

SSA,RRB,EDB

12. Claim Attending Physician   CHAR   6   39   44   On an institutional claim, the unique
    UPIN Number   physician identification number (UPIN) of the
                                                         physician who would normally be expected to
                                                         certify and recertify the medical necessity of

                                     POSITIONS
             NAME   TYPE LENGTH BEG END   CONTENTS
    ------------------------- ---- ------ --------- ---

                                                         the services rendered and/or who has primary
                                                         responsibility for the beneficiary's medical
                                                         care and treatment (attending physician).

                                                         EDIT-RULES:
                                                         REQUIRED FIELD

                                                         CODES:
                                                         1 = Male
                                                         2 = Female
                                                         0 = Unknown

                                                         SOURCE:
                                                         SSA,RRB,EDB

12. Claim Attending Physician   CHAR   6   39   44   On an institutional claim, the unique
    UPIN Number   physician identification number (UPIN) of the
                                                         physician who would normally be expected to
                                                         certify and recertify the medical necessity of
                                                         the services rendered and/or who has primary
                                                         responsibility for the beneficiary's medical
                                                         care and treatment (attending physician).

                                                         This field is ENCRYPTED for the ENCRYPTED
                                                         Standard View of the HHA files.

                                                         COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
                                                         DB2 ALIAS: ATNDG_UPIN
                                                         SAS ALIAS: AT_UPIN
                                                         STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
                                                         TITLE ALIAS: ATTENDING_PHYSICIAN

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained
                                                         10 positions (6-position UPIN and 4-position
                                                         physician surname).

                                                         SOURCE:
                                                         CWF

13. Claim Diagnosis E Code   CHAR   5   45   49   Effective with Version H, the ICD-9-CM code
                                                         used to identify the external cause of injury,
                                                         poisoning, or other adverse affect. Redundantly
                                                         this field is also stored as the last occurrence

of the diagnosis trailer.

NOTE: During the Version H conversion, the data
in the last occurrence of the diagnosis trailer
was used to populate history.

```
                                       POSITIONS
              NAME            TYPE  LENGTH BEG  END                          CONTENTS
     -------------------------  ----  ------ ---------  -----------------------------------------------------------
```

```
                                                     DB2 ALIAS: CLM_DGNS_E_CD
                                                     SAS ALIAS: DGNS_E
                                                     STANDARD ALIAS: CLM_DGNS_E_CD
                                                     TITLE ALIAS: DGNS_E_CD

                                                     SOURCE:
                                                     CWF
```

14. Claim Excepted/Nonexcepted   CHAR   1   50   50   Effective with Version I, the code used to identify
    Medical Treatment Code   whether or not the medical care or treatment received
                                                       by a beneficiary, who has elected care from a
                                                       Religious Nonmedical Health Care Institution (RNHCI),
                                                       is excepted or nonexcepted. Excepted is medical care
                                                       or treatment that is received involuntarily or is re-
                                                       quired under Federal, State or local law. Nonexcepted is
                                                       defined as medical care or treatment other than excepted.

                                                       DB2 ALIAS: EXCPTD_NEXCPTD_CD
                                                       SAS ALIAS: TRTMT_CD
                                                       STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
                                                       TITLE ALIAS: EXCPTD_NEXCPTD_CD

                                                       CODES:
                                                       0 = No Entry
                                                       1 = Excepted
                                                       2 = Nonexcepted

                                                       SOURCE:
                                                       CWF

15. Claim Facility Type Code   CHAR   1   51   51   The first digit of the type of bill (TOB1) submitted on an
                                                       institutional claim used to identify the type of facility
                                                       that provided care to the beneficiary.

                                                       COMMON ALIAS: TOB1
                                                       DB2 ALIAS: CLM_FAC_TYPE_CD
                                                       SAS ALIAS: FAC_TYPE
                                                       STANDARD ALIAS: CLM_FAC_TYPE_CD
                                                       TITLE ALIAS: TOB1

                                                       CODES:
                                                         REFER TO: CLM_FAC_TYPE_TB
                                                                 IN THE CODES APPENDIX

                                                       SOURCE:

```
16. Claim Frequency Code        CHAR     1    52   52   The third digit of the type of bill (TOB3) submitted on an
                                                        institutional claim record to indicate the sequence of a
                                                        claim in the beneficiary's current episode of care.
```

1   FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                            POSITIONS
                     NAME           TYPE  LENGTH BEG  END                        CONTENTS
         -------------------------  ----  ------ ---------  --------------------------------------------------------
```

```
                                                          COMMON ALIAS: TOB3
                                                          DB2 ALIAS: CLM_FREQ_CD
                                                          SAS ALIAS: FREQ_CD
                                                          STANDARD ALIAS: CLM_FREQ_CD
                                                          SYSTEM ALIAS: LTFREQ
                                                          TITLE ALIAS: FREQUENCY_CD

                                                          CODES:
                                                            REFER TO: CLM_FREQ_TB
                                                                      IN THE CODES APPENDIX

                                                          SOURCE:
                                                          CWF
```

```
17. Claim HHA Low Utilization     CHAR     1    53   53   Effective with Version I, the code used to identify
    Payment Adjustment (LUPA)                             those Home Health PPS claims that have 4 visits
    Indicator Code                                        or less in a 60-day episode. If an HHA provides
                                                          4 visits or less, they will be reimbursed based on
                                                          a national standardized per visit rate instead
                                                          of HHRGs.

                                                          NOTE:  Beginning 10/1/00, this field will be
                                                          populated with data.  Claims processed prior
                                                          to 10/1/00 will contain spaces.

                                                          DB2 ALIAS: HHA_LUPA_IND_CD
                                                          SAS ALIAS: LUPAIND
                                                          STANDARD ALIAS: CLM_HHA_LUPA_IND_CD
                                                          TITLE ALIAS: HHA_TOT_VISITS

                                                          CODES:
                                                          L = LUPA Claim
                                                          blank = Not a LUPA Claim

                                                          SOURCE:
                                                          CWF
```

```
18. Claim HHA Referral Code       CHAR     1    54   54   Effective with Version 'I', the codes used to
                                                          identify the means by which the beneficiary was
                                                          referred for Home Health Services.

                                                          NOTE: Beginning 10/1/00, this field will be
                                                          populated with data. Claims processed prior
                                                          to 10/1/00 will contain spaces in this field.

                                                          DB2 ALIAS: CLM_HHA_RFRL_CD
```

```
                                               SAS ALIAS: HHA_RFRL
                                               STANDARD ALIAS: CLM_HHA_RFRL_CD
                                               SYSTEM ALIAS: LTHRFRL
                                               TITLE ALIAS: HHA_REFERRAL_CODE


1        FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                    POSITIONS
              NAME          TYPE  LENGTH BEG  END                      CONTENTS
    ------------------------  ----  ------ --------  --------------------------------------------------------
                                               CODES:
                                                 REFER TO: CLM_HHA_RFRL_TB
                                                           IN THE CODES APPENDIX

                                               SOURCE:
                                               CWF


   19. Claim HHA Total Visit Count  CHAR    4    55   58  Effective with Version H, the count of the
                                               number of HHA visits as derived by CWF.

                                               NOTE1: During the Version H conversion this field
                                               was populated with data throughout history (back
                                               to service year 1991) using the CWF derivation rule
                                               (units associated with revenue center codes 042X,
                                               043X, 044X, 055X, 056X, 057X, 058X, and 059X.
                                               Value '999' will be displayed if the sum of the
                                               revenue center unit count equals or exceeds '999'.

                                               NOTE2: Effective 7/1/99, all HHA claims received
                                               with service from dates 7/1/99 and after will be
                                               processed as if the units field contains the 15
                                               minute interval count; and each visit revenue
                                               code line item will be counted as ONE visit.
                                               This field is calculated correctly; but those
                                               users who derive the count themselves will have
                                               to revise their routine. NO LONGER IS THE COUNT
                                               DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED
                                               WITH THE HHA VISIT REVENUE CODES.

                                               3 DIGITS SIGNED

                                               DB2 ALIAS: HHA_TOT_VISIT_CNT
                                               SAS ALIAS: VISITCNT
                                               STANDARD ALIAS: CLM_HHA_TOT_VISIT_CNT
                                               TITLE ALIAS: HHA_TOT_VISITS

                                               EDIT-RULES
                                               +999

                                               SOURCE:
                                               CWF

   ***  Claim Locator Number Group  GROUP   11   59   69  This number uniquely identifies the beneficiary in the
                                               NCH Nearline.

                                               STANDARD ALIAS: CLM_LCTR_NUM_GRP
```

```
     20. Beneficiary Claim Account    CHAR    9    59   67   The number identifying the primary beneficiary
         Number                                                under the SSA or RRB programs submitted.

                                                              This field is ENCRYPTED for the ENCRYPTED
                                                              Standard View of the HHA files.
```

```
                                           POSITIONS
                    NAME           TYPE  LENGTH BEG  END                         CONTENTS
         -------------------------  ----  ------ ---------  -----------------------------------------------------------
```

                                                              STANDARD ALIAS: BENE_CLM_ACNT_NUM

                                                              SOURCE:
                                                              SSA, RRB

                                                              LIMITATIONS:
                                                              RRB-issued numbers contain an overpunch in
                                                              the first position that may appear as a plus
                                                              zero or A-G.   RRB-formatted numbers may
                                                              cause matching problems on non-IBM machines.

```
     21. NCH Category Equatable     CHAR    2    68   69   The code categorizing groups of BICs representing
         Beneficiary Identification                        representing similar relationships between
         Code                                              the beneficiary and the primary wage
                                                           earner. The equatable BIC module electronically
                                                           The equatable BIC module electronially matches
                                                           matches two records that contain different BICs
                                                           where it is apparent that both are records
                                                           for the same beneficiary. It validates the BIC
                                                           and returns a base BIC under which to house
                                                           the record in the National Claims History (NCH)
                                                           databases. (All records for a beneficiary are
                                                           stored under a single BIC.)

                                                           For the ENCRYPTED Standard View, this field
                                                           contains the Beneficiary Identificaiton Code.
                                                           (See Field #7 of the FI Home Health Agency
                                                           Claim Fixed Group - Encrypted Standard View.)

     22. Claim MCO Paid Switch      CHAR    1    70   70   A switch indicating whether or not a Managed Care
                                                           Organization (MCO) has paid the provider for an
                                                           institutional claim.

                                                           COBOL ALIAS: MCO_PD_IND
                                                           DB2 ALIAS: CLM_MCO_PD_SW
                                                           SAS ALIAS: MCOPDSW
                                                           STANDARD ALIAS: CLM_MCO_PD_SW
                                                           TITLE ALIAS: MCO_PAID_SW

                                                           CODES:
                                                           1 = MCO has paid the provider for a claim
                                                           Blank or 0 = MCO has not paid the provider
                                                                        for a claim

                                                           COMMENT:
                                                           Prior to Version H this field was named:
```

```
                                          CLM_GHO_PD_SW.

                                          SOURCE:
                                          CWF

    23. Claim Medicare Non Payment   CHAR    1   71   71   The reason that no Medicare payment is made for
        Reason Code                                        services on an institutional claim.
```

```
                                  POSITIONS
                NAME          TYPE  LENGTH BEG  END                          CONTENTS
        ------------------------ ----  ------ --------- ------------------------------------------------------------

                                          NOTE:  Effective with Version I, this field was
                                                 put on all institutional claim types.
                                                 Prior to Version I, this field was present
                                                 only on inpatient/SNF claims.

                                          DB2 ALIAS: MDCR_NPMT_RSN_CD
                                          SAS ALIAS: NOPAY_CD
                                          STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
                                          SYSTEM ALIAS: LTNPMT
                                          TITLE ALIAS: NON_PAYMENT_REASON

                                          EDIT-RULES:
                                          OPTIONAL

                                          CODES:
                                            REFER TO: CLM_MDCR_NPMT_RSN_TB
                                                      IN THE CODES APPENDIX

                                          SOURCE:
                                          CWF


    24. Claim Operating Physician   CHAR    6   72   77   On an institutional claim, the unique physician
        UPIN Number                                        identification number (UPIN) of the physician
                                                           who performed the principal procedure.  This
                                                           element is used by the provider to identify the
                                                           operating physician who performed the
                                                           surgical procedure.

                                          This field is ENCRYPTED for the ENCRYPTED
                                          Standard View of the HHA files.

                                          DB2 ALIAS: OPRTG_UPIN
                                          SAS ALIAS: OP_UPIN
                                          STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
                                          TITLE ALIAS: OPRTG_UPIN

                                          COMMENT:
                                          Prior to Version H this field was named:
                                          CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained
                                          10 positions (6-position UPIN and 4-position
                                          physician surname.

                                          NOTE:  For HHA and Hospice formats beginning
```

with NCH weekly process date 10/3/97 this field
was populated with data. HHA and Hospice claims
processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
25. Claim Other Physician UPIN Number	CHAR	6	78	83	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

This field is ENCRYPTED for the ENCRYPTED
Standard View of the HHA files.

DB2 ALIAS: OTHR_UPIN
SAS ALIAS: OT_UPIN
STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
TITLE ALIAS: OTH_PHYSN_UPIN

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_PHYSN_IDENT_NUM and contained
10 positions (6-position UPIN and 4-position
other physician surname).

NOTE: For HHA and Hospice formats beginning
with NCH weekly process date 10/3/97 this field
was populated with data. HHA and Hospice claims
processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

| 26. Claim Payment Amount | CHAR | 13 | 84 | 96 | Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) |

Under IP PPS, inpatient hospital services are paid based on
a predetermined rate per discharge, using the DRG patient
classification system and the PRICER program.   On the IP
PPS claim, the payment amount includes the DRG outlier

approved payment amount, disproportionate share (since
5/1/86), indirect medical education (since 10/1/88), total
PPS capital (since 10/1/91). It does NOT include the pass
thru amounts (i.e., capital-related costs, direct medical
education costs, kidney acquisition costs, bad debts); or
any beneficiary-paid amounts (i.e., deductibles and
coinsurance); or any other payer reimbursement.

```
                                POSITIONS
            NAME            TYPE  LENGTH BEG  END                            CONTENTS
------------------------    ----  ------ --------- ----------------------------------------------------------
```

Under SNF PPS, SNFs will classify beneficiaries using the
patient classification system known as RUGS III. For the
SNF PPS claim, the SNF PRICER will calculate/return the rate
for each revenue center line item with revenue center code =
'0022'; multiply the rate times the units count; and then
sum the amount payable for all lines with revenue center
code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment
classification (APC) rate that is calculated for each APC
group is the basis for determining the total payment. The
Medicare payment amount takes into account the wage index
adjustment and the beneficiary deductible and coinsurance
amounts. NOTE: There is no CWF edit check to validate that
the revenue center Medicare payment amount equals the claim
level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified into
an appropriate case mix category known as the Home Health
Resource Group. A HIPPS code is then generated
corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount
appropriate to the HIPPS code by computing 60% (for first
episode) or 50% (for subsequent episodes) of the case mix
episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount
due, because the final claim is processed as an adjustment
to the RAP, reversing the RAP payment in full. Although
final claim will show 100% payment amount, the provider will
actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter
data, the amount reported in this field may not just
represent the actual provider payment.

     For demo Ids '01','02','03','04' -- claims contain
     amount paid to the provider, except that special
     'differentials' paid outside the normal payment system
     are not included.

     For demo Ids '05','15' -- encounter data 'claims'
     contain amount Medicare would have paid under FFS,

instead of the actual payment to the MCO.

                               For demo Ids '06','07','08' -- claims contain actual
                               provider payment but represent a special negotiated
                               bundled payment for both Part A and Part B services.
                               To identify what the conventional provider Part A
                               payment would have been, check value code = 'Y4'. The
                               related noninstitutional (physician/supplier) claims
                               contain what would have been paid had there been no
                               demo.

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                            POSITIONS
          NAME   TYPE LENGTH BEG END   CONTENTS
-------------------------   ---- ------ --------- --

                               For BBA encounter data (non-demo) -- 'claims' contain
                               amount Medicare would have paid under FFS, instead of
                               the actual payment to the BBA plan.

                               9.2 DIGITS SIGNED

                               COMMON ALIAS: REIMBURSEMENT
                               DB2 ALIAS: CLM_PMT_AMT
                               SAS ALIAS: PMT_AMT
                               STANDARD ALIAS: CLM_PMT_AMT
                               TITLE ALIAS: REIMBURSEMENT

                               EDIT-RULES:
                               +9(9).99

                               COMMENT:
                               Prior to Version H the size of this field was S9(7)V99.
                               Also the noninstitutional claim records carried this field
                               as a line item. Effective with Version H, this element is
                               a claim level field across all claim types (and the line
                               item field has been renamed.)

                               SOURCE:
                               CWF

                               LIMITATIONS:
                               Prior to 4/6/93, on inpatient, outpatient, and
                               physician/supplier claims containing a
                               CLM_DISP_CD of '02', the amount shown as the Medicare
                               reimbursement does not take into consideration
                               any CWF automatic adjustments (involving erroneous
                               deductibles in most cases). In as many as 30% of
                               the claims (30% IP, 15% OP, 5% PART B), the
                               reimbursement reported on the claims may be over
                               or under the actual Medicare payment amount.

27. Claim PPS Indicator Code   CHAR   1   97   97 Effective with Version H, the code indicating
                                                    whether or not the (1) claim is PPS and/or (2)
                                                    the beneficiary is a deemed insured Medicare
                                                    Qualified Government Employee (MQGE).

```
                              NOTE:  Beginning with NCH weekly process date
                              10/3/97 through 5/29/98, this field was pop-
                              ulated with only the PPS indicator.  Beginning with
                              NCH weekly process date 6/5/98, this field was
                              additionally populated with the deemed MQGE
                              indicator. Claims processed prior to 10/3/97
                              will contain spaces.

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                                    POSITIONS
                  NAME          TYPE  LENGTH BEG  END                        CONTENTS
         -------------------------  ----  ------ ---------  --------------------------------------------------------------

                                                            COBOL ALIAS: PPS_IND
                                                            DB2 ALIAS: CLM_PPS_IND_CD
                                                            SAS ALIAS: PPS_IND
                                                            STANDARD ALIAS: CLM_PPS_IND_CD
                                                            TITLE ALIAS: PPS_IND

                                                            CODES:
                                                              REFER TO: CLM_PPS_IND_TB
                                                                        IN THE CODES APPENDIX

                                                            SOURCE:
                                                            CWF

      28. Claim Principal Diagnosis  CHAR    5    98   102  The ICD-9-CM diagnosis code identifying the diagnosis,
          Code                                             condition, problem or other reason for the
                                                            admission/encounter/visit shown in the medical record
                                                            to be chiefly responsible for the services provided.

                                                            NOTE:  Effective with Version H, this data is also
                                                            redundantly stored as the first occurrence of the diagnosis
                                                            trailer.

                                                            DB2 ALIAS: PRNCPAL_DGNS_CD
                                                            SAS ALIAS: PDGNS_CD
                                                            STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
                                                            TITLE ALIAS: PRINCIPAL_DIAGNOSIS

                                                            EDIT-RULES:
                                                            ICD-9-CM

                                                            SOURCE:
                                                            CWF


      29. Claim Query Code         CHAR    1   103   103   Code indicating the type of claim record being processed
                                                            with respect to payment (debit/credit indicator;
                                                            interim/final indicator).

                                                            DB2 ALIAS: CLM_QUERY_CD
                                                            SAS ALIAS: QUERY_CD
                                                            STANDARD ALIAS: CLM_QUERY_CD
                                                            TITLE ALIAS: QUERY_CD

                                                            CODES:
```

```
                                   0 = Credit adjustment
                                   1 = Interim bill
                                   2 = Home Health Agency (HHA) benefits
                                       exhausted (obsolete 7/98)
                                   3 = Final bill
                                   4 = Discharge notice (obsolete 7/98)
                                   5 = Debit adjustment

                                   SOURCE:
                                   CWF
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                                  POSITIONS
                NAME           TYPE  LENGTH BEG  END                          CONTENTS
    --------------------------- ----  ------ ---------  ------------------------------------------------------------

    30. Claim Service          CHAR    1    104  104   The second digit of the type of bill (TOB2) submitted on an
        Classification Type Code                       institutional claim record to indicate the classification of
                                                       the type of service provided to the beneficiary.

                                                       COMMON ALIAS: TOB2
                                                       DB2 ALIAS: SRVC_CLSFCTN_CD
                                                       SAS ALIAS: TYPESRVC
                                                       STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
                                                       TITLE ALIAS: TOB2

                                                       CODES:
                                                          REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
                                                                       IN THE CODES APPENDIX

                                                       SOURCE:
                                                       CWF

    31. Claim Through Date      NUM     8    105  112   The last day on the billing statement covering
                                                       services rendered to the beneficiary (a.k.a
                                                       'Statement Covers Thru Date').

                                                       For the ENCRYPTED Standard View of the
                                                       HHA files, the claim through date is
                                                       coded as the quarter of the calendar
                                                       year when the claim through date
                                                       occurred.

                                                       NOTE:  For Home Health PPS claims, the 'from'
                                                       date and the 'thru' date on the RAP (initial
                                                       claim) must always match.

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: CLM_THRU_DT
                                                       SAS ALIAS: THRU_DT
                                                       STANDARD ALIAS: CLM_THRU_DT
                                                       TITLE ALIAS: THRU_DATE

                                                       EDIT-RULES FOR ENCRYPTED DATA:
                                                       YYYYQ000 WHERE Q IS ONE OF THE
                                                       FOLLOWING VALUES.
                                                       1 = FIRST QUARTER OF THE CALENDAR YEAR
```

```
                                          2 = SECOND QUARTER OF THE CALENDAR YEAR
                                          3 = THIRD QUARTER OF THE CALENDAR YEAR
                                          4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                          SOURCE:
                                          CWF

   32. Claim Total Charge Amount    CHAR    13  113  125   Effective with Version G, the total charges for
                                                           all services included on the institutional claim.
                                                           This field is redundant with revenue center
                                                           code 0001/total charges.
```

```
                                     POSITIONS
              NAME              TYPE   LENGTH BEG  END                      CONTENTS
   -------------------------    ----   ------ ---------   ------------------------------------------------------

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: CLM_TOT_CHRG_AMT
                                                         SAS ALIAS: TOT_CHRG
                                                         STANDARD ALIAS: CLM_TOT_CHRG_AMT
                                                         TITLE ALIAS: CLAIM_TOTAL_CHARGES

                                                         EDIT-RULES:
                                                         +9(9).99

                                                         COMMENT:
                                                         Prior to Version H the size of this field was
                                                         S9(7)V99.

                                                         SOURCE:
                                                         CWF

   33. Claim Transaction Code     CHAR     1   126  126   The code derived by CWF to indicate the type of claim
                                                          submitted by an institutional provider.

                                                          DB2 ALIAS: CLM_TRANS_CD
                                                          SAS ALIAS: TRANS_CD
                                                          STANDARD ALIAS: CLM_TRANS_CD
                                                          SYSTEM ALIAS: LTCLTRAN
                                                          TITLE ALIAS: TRANSACTION_CODE

                                                          CODES:
                                                            REFER TO: CLM_TRANS_TB
                                                                      IN THE CODES APPENDIX

                                                          SOURCE:
                                                          CWF

   34. CWF Beneficiary Medicare   CHAR     2   127  128   The CWF-derived reason for a beneficiary's
       Status Code                                        entitlement to Medicare benefits, as of the
                                                          reference date (CLM_THRU_DT).

                                                          COBOL ALIAS: MSC
                                                          COMMON ALIAS: MSC
                                                          DB2 ALIAS: BENE_MDCR_STUS_CD
```

```
                                          SAS ALIAS: MS_CD
                                          STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
                                          SYSTEM ALIAS: LTMSC
                                          TITLE ALIAS: MSC

                                          DERIVATION:
                                          CWF derives MSC from the following:
                                            1.  Date of Birth
                                            2.  Claim Through Date
                                            3.  Original/Current Reasons for entitlement
                                            4.  ESRD Indicator
                                            5.  Beneficiary Claim Number
```
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```
                                POSITIONS
              NAME          TYPE  LENGTH BEG  END                          CONTENTS
    -------------------------  ----  ------ --------  -------------------------------------------------------------
                                          DERIVATION:
                                          CWF derives MSC from the following:
                                            1.  Date of Birth
                                            2.  Claim Through Date
                                            3.  Original/Current Reasons for entitlement
                                            4.  ESRD Indicator
                                            5.  Beneficiary Claim Number
                                          Items 1,3,4,5 come from the CWF Beneficiary
                                          Master Record; item 2 comes from the FI/Carrier
                                          claim record.  MSC is assigned as follows:

                                            MSC   OASI   DIB    ESRD    AGE          BIC
                                            ____  ____  ____  ____  ____        ____
                                            10    YES   N/A    NO     65 and over  N/A
                                            11    YES   N/A    YES    65 and over  N/A
                                            20    NO    YES    NO     under 65     N/A
                                            21    NO    YES    YES    under 65     N/A
                                            31    NO    NO     YES    any age      T.

                                          CODES:
                                          10 = Aged without ESRD
                                          11 = Aged with ESRD
                                          20 = Disabled without ESRD
                                          21 = Disabled with ESRD
                                          31 = ESRD only

                                          COMMENT:
                                          Prior to Version H this field was named:
                                          BENE_MDCR_STUS_CD.  The name has been changed
                                          to distinguish this CWF-derived field from the
                                          EDB-derived MSC (BENE_MDCR_STUS_CD).

                                          SOURCE:
                                          CWF

    35. FI Claim Action Code    CHAR    1   129  129  The type of action requested by the intermediary
                                          to be taken on an institutional claim.

                                          DB2 ALIAS: FI_CLM_ACTN_CD
```

```
                                              SAS ALIAS: ACTIONCD
                                              STANDARD ALIAS: FI_CLM_ACTN_CD
                                              TITLE ALIAS: ACTION_CD


                                              CODES:
                                                REFER TO: FI_CLM_ACTN_TB
                                                          IN THE CODES APPENDIX


                                              COMMENT:
                                              Prior to Version H this field was named:
                                              INTRMDRY_CLM_ACTN_CD.


                                              SOURCE:
                                              CWF
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                                POSITIONS
                NAME             TYPE  LENGTH BEG  END                        CONTENTS
     ------------------------- ---- ------ --------- ------------------------------------------------------------

     36. FI Number               CHAR    5  130  134  The identification number assigned by HCFA to a fiscal
                                                      intermediary authorized to process institutional claim
                                                      records.

                                                      DB2 ALIAS: FI_NUM
                                                      SAS ALIAS: FI_NUM
                                                      STANDARD ALIAS: FI_NUM
                                                      SYSTEM ALIAS: LTFI
                                                      TITLE ALIAS: INTERMEDIARY

                                                      CODES:
                                                        REFER TO: FI_NUM_TB
                                                                  IN THE CODES APPENDIX

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      FICARR_IDENT_NUM.

                                                      SOURCE:
                                                      CWF

     37. FI Requested Claim Cancel  CHAR  1  135  135  The reason that an intermediary requested cancelling
         Reason Code                                   a previously submitted institutional claim.

                                                      DB2 ALIAS: RQST_CNCL_RSN_CD
                                                      SAS ALIAS: CANCELCD
                                                      STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
                                                      TITLE ALIAS: CANCEL_CD

                                                      CODES:
                                                        REFER TO: FI_RQST_CLM_CNCL_RSN_TB
                                                                  IN THE CODES APPENDIX

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      INTRMDRY_RQST_CLM_CNCL_RSN_CD.

                                                      SOURCE:
```

```
                                      CWF

    38. HHA Claim Diagnosis       NUM      2   136 137  The count of the number of diagnosis codes (both principal
        Code Count                                      and other) reported on an HHA claim.  The purpose
                                                        of this count is to indicate how many claim diagnosis
                                                        trailers are present.

                                                        2 DIGITS UNSIGNED

                                                        DB2 ALIAS: HHA_DGNS_CD_CNT
                                                        SAS ALIAS: HHDGNCNT
                                                        STANDARD ALIAS: HHA_CLM_DGNS_CD_CNT

                                                        EDIT-RULES:
                                                        RANGE: 0 TO 10
```

```
                                             POSITIONS
                  NAME           TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------    ----  ------ ---------  -----------------------------------------------------------

                                                        COMMENT:
                                                        Prior to Version H this field was named:
                                                        CLM_OTHR_DGNS_CD_CNT and the principal was
                                                        not included in the count.

                                                        SOURCE:
                                                        CWF

    39. HHA Claim Related         NUM      2   138 139  The count of the number of condition codes reported
        Condition Code Count                            on an HHA claim.  The purpose of this count is to
                                                        indicate how many condition code trailers are present.

                                                        2 DIGITS UNSIGNED

                                                        DB2 ALIAS: HHA_COND_CD_CNT
                                                        SAS ALIAS: HHCONCNT
                                                        STANDARD ALIAS: HHA_CLM_RLT_COND_CD_CNT

                                                        EDIT-RULES:
                                                        RANGE: 0 TO 30

                                                        COMMENT:
                                                        Prior to Version H this field was named:
                                                        CLM_RLT_COND_CD_CNT.

                                                        SOURCE:
                                                        CWF

    40. HHA Claim Related         NUM      2   140 141  The count of the number of occurrence codes reported
        Occurrence Code Count                           on an HHA claim.  The purpose of this count is to
                                                        indicate how many occurrence code trailers are present.

                                                        2 DIGITS UNSIGNED

                                                        DB2 ALIAS: HHA_RLT_OCRNC_CNT
                                                        SAS ALIAS: HHOCRCNT
```

```
                                      STANDARD ALIAS: HHA_CLM_RLT_OCRNC_CD_CNT

                                      EDIT-RULES:
                                      RANGE: 0 TO 30

                                      COMMENT:
                                      Prior to Version H this field was named:
                                      CLM_RLT_OCRNC_CD_CNT.

                                      SOURCE:
                                      CWF

     41. HHA Claim Value        NUM     2   142  143   The count of the number of value codes reported
         Code Count                                    on an HHA claim.  The purpose of the count
                                                       is to indicate how many value code trailers are
                                                       present.

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                                      POSITIONS
               NAME            TYPE  LENGTH BEG  END                      CONTENTS
     -------------------------- ----  ------ ---------   -------------------------------------------------------
                                                       2 DIGITS UNSIGNED

                                                       DB2 ALIAS: HHA_CLM_VAL_CD_CNT
                                                       SAS ALIAS: HHVALCNT
                                                       STANDARD ALIAS: HHA_CLM_VAL_CD_CNT

                                                       EDIT-RULES:
                                                       RANGE: 0 TO 36

                                                       COMMENT:
                                                       Prior to Version H this field was named:
                                                       CLM_VAL_CD_CNT.

                                                       SOURCE:
                                                       CWF

     42. HHA Revenue Center     NUM     2   144  145   The count of the number of revenue codes
         Code Count                                    reported on an HHA claim.  The purpose
                                                       of the count is to indicate how many
                                                       revenue center trailers are present.

                                                       2 DIGITS UNSIGNED

                                                       DB2 ALIAS: HHA_REV_CNTR_CD_CNT
                                                       SAS ALIAS: HHREVCNT
                                                       STANDARD ALIAS: HHA_REV_CNTR_CD_I_CNT

                                                       EDIT-RULES:
                                                       RANGE: 0 TO 45

                                                       COMMENT:
                                                       Prior to Version H this field was named:
                                                       CLM_REV_CNTR_CD_CNT.

                                                       NOTE:  During the Version 'I' conversion the
```

```
                                  number of occurrences changed to 45 (per
                                  segment - 450 total for claim).  For
                                  claims prior to Version 'I' the number of
                                  occurrences was 58, but in the conversion
                                  we made all claims back to service year
                                  1991 contain only 45 revenue center lines.
                                  It is possible that claims prior to 1991
                                  will have 2 segments if they contained
                                  more than 45 revenue lines.

                                  SOURCE:
                                  CWF

    43. NCH Beneficiary Discharge    NUM    8   146  153   Effective with Version H, on an inpatient and
        Date                                                HHA claim, the date the beneficiary was discharged
                                                            from the facility or died (used for internal CWFMQA
                                                            editing purposes.)
```

```
                                  POSITIONS
          NAME                 TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------  ----  ------ ---------  -----------------------------------------------------------

                                  For the ENCRYPTED Standard View of the
                                  HHA files, the beneficiary's discharge
                                  date is coded as the quarter of the
                                  calendar year when the discharge occurred.

                                  NOTE:  During the Version H conversion this field
                                  was populated with data throughout history (back to
                                  service year 1991.)

                                  8 DIGITS UNSIGNED

                                  DB2 ALIAS: NCH_BENE_DSCHRG_DT
                                  SAS ALIAS: DSCHRGDT
                                  STANDARD ALIAS: NCH_BENE_DSCHRG_DT
                                  TITLE ALIAS: DISCHARGE_DT

                                  EDIT-RULES FOR ENCRYPTED DATA:
                                  YYYYQ000 WHERE Q IS ONE OF THE
                                  FOLLOWING VALUES.
                                  1 = FIRST QUARTER OF THE CALENDAR YEAR
                                  2 = SECOND QUARTER OF THE CALENDAR YEAR
                                  3 = THIRD QUARTER OF THE CALENDAR YEAR
                                  4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                  DERIVATION:
                                  DERIVED FROM:
                                    NCH_PTNT_STUS_IND_CD
                                    CLM_THRU_DT

                                  DERIVATION RULES:
                                  Based on the presence of patient discharge status
                                  code not equal to 30 (still patient), move the claim
                                  thru date to the NCH_BENE_DSCHRG_DT.
```

```
                                              SOURCE:
                                              NCH QA Process

     44. NCH Near Line Record         CHAR    1   154  154  A code defining the type of claim record being processed.
         Identification Code

                                              COMMON ALIAS:  RIC
                                              DB2 ALIAS:  NEAR_LINE_RIC_CD
                                              SAS ALIAS:  RIC_CD
                                              STANDARD ALIAS:  NCH_NEAR_LINE_RIC_CD
                                              TITLE ALIAS:  RIC

                                              CODES:
                                                REFER TO: NCH_NEAR_LINE_RIC_TB
                                                          IN THE CODES APPENDIX

                                              COMMENT:
                                              Prior to Version H this field was named:
                                              RIC_CD.

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                                       POSITIONS
            NAME               TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------  ----  ------ ---------  --------------------------------------------------------

                                              SOURCE:
                                              NCH

     45. NCH Near-Line Record       CHAR    1   155  155  The code indicating the record version of the Nearline file
         Version Code                                     where the institutional, carrier or DMERC claims data are
                                                          stored:

                                              DB2 ALIAS:  NCH_REC_VRSN_CD
                                              SAS ALIAS:  REC_LVL
                                              STANDARD ALIAS:  NCH_NEAR_LINE_REC_VRSN_CD
                                              TITLE ALIAS:  NCH_VERSION

                                              CODES:
                                              A = Record format as of January 1991
                                              B = Record format as of April 1991
                                              C = Record format as of May 1991
                                              D = Record format as of January 1992
                                              E = Record format as of March 1992
                                              F = Record format as of May 1992
                                              G = Record format as of October 1993
                                              H = Record format as of September 1998
                                              I = Record format as of July 2000

     46. NCH Payment and Edit Record  CHAR    1   156  156  The code used for payment and editing purposes that
         Identification Code                               indicates the type of institutional claim record.

                                              DB2 ALIAS: PMT_EDIT_RIC_CD
                                              SAS ALIAS: PE_RIC
                                              STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD
                                              TITLE ALIAS: NCH_PAYMENT_EDIT_RIC

                                              CODES:
                                              C = Inpatient hospital, SNF
```

```
                          D = Outpatient
                          E = Religious Nonmedical Health Care Institutions (eff. 8/00
                             Christian Science, prior to 7/00
                          F = Home Health Agency (HHA)
                          G = Discharge notice
                             (obsoleted 7/98)
                          I = Hospice


                          COMMENT:
                          Prior to Version H this field was named:
                          PMT_EDIT_RIC_CD.

                          SOURCE:
                          NCH QA Process

    47. NCH Primary Payer Claim      CHAR    13   157  169   The amount of a payment made on behalf of a Medicare
        Paid Amount                                          beneficiary by a primary payer other than Medicare, that the
                                                             provider is applying to covered Medicare charges on an
                                                             institutional, carrier, or DMERC claim.

                                                             9.2 DIGITS SIGNED

1       FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002


                                     POSITIONS
                NAME            TYPE  LENGTH BEG  END                           CONTENTS
        -------------------------   ----  ------ ---------   ------------------------------------------------------------


                                                             DB2 ALIAS: PRMRY_PYR_PD_AMT
                                                             SAS ALIAS: PRPAYAMT
                                                             STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
                                                             TITLE ALIAS: PRIMARY_PAYER_AMOUNT

                                                             EDIT-RULES:
                                                             +9(9).99

                                                             COMMENT:
                                                             Prior to Version H this field was named:
                                                             BENE_PRMRY_PYR_CLM_PMT_AMT and the field size
                                                             was S9(7)V99.

                                                             SOURCE:
                                                             NCH

    48. NCH Primary Payer Code       CHAR     1   170  170   The code, on an institutional claim, specifying a federal
                                                             non-Medicare program or other source that has primary
                                                             responsibility for the payment of the Medicare beneficiary's
                                                             health insurance bills.

                                                             DB2 ALIAS: NCH_PRMRY_PYR_CD
                                                             SAS ALIAS: PRPAY_CD
                                                             STANDARD ALIAS: NCH_PRMRY_PYR_CD
                                                             TITLE ALIAS: PRIMARY_PAYER_CD

                                                             DERIVATION:
                                                             DERIVED FROM:
                                                               CLM_VAL_CD
                                                               CLM_VAL_AMT
```

```
                        DERIVATION RULES

                           SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
                           CLM_VAL_CD = '12'

                           SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
                           CLM_VAL_CD = '13'

                           SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
                           CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

                           SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE
                           CLM_VAL_CD = '14'

                           SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE
                           CLM_VAL_CD = '15'

                           SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE
                           CLM_VAL_CD = '16' (CLM_VAL_AMT not
                           equal to zeroes)
```

```
                              POSITIONS
           NAME             TYPE  LENGTH BEG  END                        CONTENTS
   -------------------------- ---- ------ ---------  -----------------------------------------------------------
                                                     SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE
                                                     CLM_VAL_CD = '43'

                                                     SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE
                                                     CLM_VAL_CD = '41'

                                                     SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE
                                                     CLM_VAL_CD = '42'

                                                     SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97
                                                     set code to 'J') WHERE THE CLM_VAL_CD = '47'

                                                     CODES:
                                                       REFER TO: BENE_PRMRY_PYR_TB
                                                                 IN THE CODES APPENDIX

                                                     COMMENT:
                                                     Prior to Version H this field was named:
                                                     BENE_PRMRY_PYR_CD.

                                                     SOURCE:
                                                     NCH

   49. NCH Provider State Code   CHAR    2   171  172  Effective with Version H, the two position SSA state code
                                                     where provider facility is located.

                                                     NOTE:  During the Version H conversion this field was
                                                     populated with data throughout history (back to service year
                                                     1991).
```

```
                                DB2 ALIAS: NCH_PRVDR_STATE_CD
                                SAS ALIAS: PRSTATE
                                STANDARD ALIAS: NCH_PRVDR_STATE_CD
                                TITLE ALIAS: PROVIDER_STATE_CD

                                DERIVATION:
                                DERIVED FROM:
                                  NCH PRVDR_NUM

                                DERIVATION RULES:

                                  SET NCH_PRVDR_STATE_CD TO
                                      PRVDR_NUM POS1-2.
                                  FOR PRVDR_NUM POS1-2 EQUAL '55
                                    SET NCH_PRVDR_STATE_CD TO '05'.
                                  FOR PRVDR_NUM POS1-2 EQUAL '67
                                    SET NCH_PRVDR_STATE_CD TO '45'.
                                  FOR PRVDR_NUM POS1-2 EQUAL '68
                                    SET NCH_PRVDR_STATE_CD TO '10'.

                                CODES:
                                  REFER TO: GEO_SSA_STATE_TB
                                            IN THE CODES APPENDIX
```

```
                                  POSITIONS
             NAME              TYPE  LENGTH BEG  END                           CONTENTS
-------------------------      ----  ------ ---------  ------------------------------------------------------------

                                                       SOURCE:
                                                       NCH

50. NCH Qualify Stay Through   NUM      8   173  180   Effective with Version H, the ending date of
    Date                                                the beneficiary's qualifying stay (used for internal
                                                       CWFMQA editing purposes.)   For inpatient claims, the
                                                       date relates to the PPS portion of the inlier for
                                                       which there is no utilization to benefits. For
                                                       SNF claims, the date relates to a qualifying stay
                                                       from a hospital that is at least two days in a row
                                                       if the source of admission is an 'A', or at least
                                                       three days in a row if the source of admission
                                                       is other than 'A'.

                                                       For the ENCRYPTED Standard View of the
                                                       HHA files, the beneficiary's qualifying stay
                                                       through date is coded as the quarter of
                                                       calendar year when the stay through date
                                                       occurred.

                                                       NOTE:  During the Version H, conversion this field
                                                       was populated with data throughout history (back to
                                                       service year 1991).

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: QLFY_STAY_THRU_DT
                                                       SAS ALIAS: QLFYTHRU
```

```
                                        STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT
                                        TITLE ALIAS: QLFYG_STAY_THRU_DT

                                        EDIT-RULES FOR ENCRYPTED DATA:
                                        YYYYQ000 WHERE Q IS ONE OF THE
                                        FOLLOWING VALUES.
                                        1 = FIRST QUARTER OF THE CALENDAR YEAR
                                        2 = SECOND QUARTER OF THE CALENDAR YEAR
                                        3 = THIRD QUARTER OF THE CALENDAR YEAR
                                        4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                        DERIVATION:
                                        DERIVED FROM:
                                          CLM_OCRNC_SPAN_CD
                                          CLM_OCRNC_SPAN_THRU_DT

                                        DERIVATION RULES:
                                        Based on the presence of occurrence code 70
                                        move the related occurrence thru date to
                                        NCH_QLFY_STAY_THRU_DT.

                                        SOURCE:
                                        NCH QA Process
```

```
                                    POSITIONS
                  NAME             TYPE  LENGTH BEG  END                      CONTENTS
        -------------------------  ----  ------ ---------  ---------------------------------------------------------

        51. Patient Discharge Status   CHAR     2   181  182  The code used to identify the status of the
            Code                                               patient as of the CLM_THRU_DT.

                                                               COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
                                                               DB2 ALIAS: PTNT_DSCHRG_STUS
                                                               SAS ALIAS: STUS_CD
                                                               STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
                                                               SYSTEM ALIAS: LTCLMST
                                                               TITLE ALIAS: PTNT_DSCHRG_STUS_CD

                                                               CODES:
                                                                 REFER TO: PTNT_DSCHRG_STUS_TB
                                                                           IN THE CODES APPENDIX

                                                               COMMENT:
                                                               Prior to Version H this field was named:
                                                               CLM_STUS_CD.

                                                               SOURCE:
                                                               CWF

        52. Provider Number            CHAR     6   183  188  The identification number of the institutional provider
                                                               certified by Medicare to provide services to the
                                                               beneficiary.

                                                               DB2 ALIAS: PRVDR_NUM
                                                               SAS ALIAS: PROVIDER
                                                               STANDARD ALIAS: PRVDR_NUM
```

```
                              TITLE ALIAS: PROVIDER_NUMBER

                              CODES:
                                REFER TO: PRVDR_NUM_TB
                                          IN THE CODES APPENDIX

                              SOURCE:
                              OSCAR
```

```
   53.  HEADER-GRP.                 GROUP     50

       1. System-User           CHAR     30 189   218  A user-defined field that holds the description of the
                                                        request. For example, "Cross-referenced HICs".

       2. Filler             CHAR     11 219   229  Filler

       3. Desy-Sort-Key      CHAR      9 230   238  This field contains the key to tie claims together for
                                                    one beneficiary regardless of HICAN.
```

```
   ********************************************************************************************************

                 C L A I M     D I A G N O S I S     G R O U P     R E C O R D

   ********************************************************************************************************
```

```
                                     POSITIONS
              NAME            TYPE  LENGTH BEG  END                        CONTENTS
   -------------------------  ----  ------ ---------  -----------------------------------------------------------
 ****  FI HHA Claim          GROUP    26                Claim Diagnosis Group Record
       Diagnosis Group                                  for the Encrypted Standard View of the
       Record - Encrypted                               HHA version I NCH Nearline File.
       Standard View
                                                        The number of claim diagnosis trailers is
                                                        determined by the claim diagnosis code
                                                        count.  The principal diagnosis is the first occurrence.
                                                        The 'E' code (ICD-9-CM code for the external cause
                                                        of an injury, poisoning, or adverse affect) is
                                                        stored as the last occurrence.
                                                        The principal diagnosis and the 'E' code are also
                                                        stored (redundantly) in the fixed record.

                                                        NOTE:
                                                        Prior to Version H this group was named:
                                                        CLM_OTHR_DGNS_GRP and did not contain the
                                                        CLM_PRNCPAL_DGNS_CD.

                                                        OCCURS: UP TO 10 TIMES
                                                                DEPENDING ON HHA_CLM_DGNS_CD_CNT

                                                        STANDARD ALIAS: UTLHHAI_CLM_DGNS_GRP
```

```
    1. Record Length Count          NUM      5    1    5   The length of the Claim Diagnosis Group Record.

                                                          5 DIGITS UNSIGNED

                                                          STANDARD ALIAS: TRAIL_BYTE_COUNT

    2. Record Number                NUM      9    6   14   A sequentially assigned number for the claims included
                                                          in the file. This number allows the user to link all of
                                                          the records associated with one claim.

                                                          STANDARD ALIAS: TRAIL_CLAIM_NO

    3. Record Type                  NUM      2   15   16   Type of Record.

                                                          STANDARD ALIAS: TRAIL_REC_TYPE

                                                          CODES:
                                                          00 = Fixed/Main Group
                                                          01 = Carrier Line Group
                                                          02 = Claim Demonstration ID Group
                                                          03 = Claim Diagnosis Group
                                                          04 = Claim Health PlanID Group
```

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```
                                       POSITIONS
              NAME              TYPE  LENGTH BEG   END                            CONTENTS
    --------------------------  ----  ------ ---------  -------------------------------------------------------------
                                                          05 = Claim Occurrence Span Group
                                                          06 = Claim Procedure Group
                                                          07 = Claim Related Condition Group
                                                          08 = Claim Related Occurrence Group
                                                          09 = Claim Value Group
                                                          10 = MCO Period Group
                                                          11 = NCH Edit Group
                                                          12 = NCH Patch Group
                                                          13 = DMERC Line Group
                                                          14 = Revenue Center Group

    4. Claim Sequence Number        NUM      3   17   19   A counter for records that consist of trailer
                                                          information, such as claim line and revenue center
                                                          data, which can occur multiple times for one claim.

                                                          STANDARD ALIAS: TRAIL_CLAIM_SEQ

    5. NCH Claim Type Code          CHAR     2   20   21   The code used to identify the type of claim record being
                                                          processed in NCH.

                                                          NOTE1:  During the Version H conversion this field was
                                                                  populated with data through- out history (back to
                                                                  service year 1991).

                                                          NOTE2:  During the Version I conversion this field was
                                                                  expanded to include inpatient 'full' encounter
                                                                  claims (for service dates after 6/30/97).
```

```
                           Placeholders for Physician and Outpatient encounters
                           (available in NMUD) have also been added.

                      STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                      DERIVATION:
                      FFS CLAIM TYPE CODES DERIVED FROM:
                        NCH CLM_NEAR_LINE_RIC_CD
                        NCH PMT_EDIT_RIC_CD
                        NCH CLM_TRANS_CD
                        NCH PRVDR_NUM

                      INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                        (Pre-HDC processing -- AVAILABLE IN NCH)
                        CLM_MCO_PD_SW
                        CLM_RLT_COND_CD
                        MCO_CNTRCT_NUM
                        MCO_OPTN_CD
                        MCO_PRD_EFCTV_DT
                        MCO_PRD_TRMNTN_DT

                      INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                        (HDC processing -- AVAILABLE IN NMUD)
                        FI_NUM
```

```
                                    POSITIONS
                NAME            TYPE  LENGTH BEG  END                        CONTENTS
       -------------------------  ----  ------ ---------  ------------------------------------------------------------
                                                      INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                      FROM: (HDC processing -- AVAILABLE IN NMUD)
                                                        FI_NUM
                                                        CLM_FAC_TYPE_CD
                                                        CLM_SRVC_CLSFCTN_TYPE_CD
                                                        CLM_FREQ_CD
                                                      NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                      abbreviated inpatient encounter claims are not
                                                      available in NCH or NMUD.

                                                      PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                        (AVAILABLE IN NMUD)
                                                        CARR_NUM
                                                        CLM_DEMO_ID_NUM

                                                      OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                        (AVAILABLE IN NMUD)
                                                        FI_NUM

                                                      OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                      DERIVED FROM:  (AVAILABLE IN NMUD)
                                                        FI_NUM
                                                        CLM_FAC_TYPE_CD
                                                        CLM_SRVC_CLSFCTN_TYPE_CD
                                                        CLM_FREQ_CD

                                                      DERIVATION RULES:
```

```
SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2.   PMT_EDIT_RIC_CD EQUAL 'F'
3.   CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '0' OR '4'
4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
     OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '0' OR '4'
4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
     OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
```

```
                            POSITIONS
          NAME             TYPE  LENGTH BEG  END              CONTENTS
-------------------------  ----  ------ ---------  ------------------------------------------------------------
```

```
3.   CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.   PMT_EDIT_RIC_CD EQUAL 'D'
3.   CLM_TRANS_CD EQUAL '6'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1.   FI_NUM = 80881
2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
     CLSFCTN_TYPE_CD = '2', '3' OR '4' &
     CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'I'
3.   CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
```

WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_MCO_PD_SW = '1'
2.   CLM_RLT_COND_CD = '04'
3.   MCO_CNTRCT_NUM
      MCO_OPTN_CD = 'C'
      CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
      MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
      ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
      TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

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| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD on DMEPOS table (NOTE: if one or
      more line item(s) match the HCPCS on the
      DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:
1.   CARR_NUM = 80882 AND
2.   CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
   CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

```
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                        2.   HCPCS_CD not on DMEPOS table

                                        SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                        2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                             more line item(s) match the HCPCS on the
                                             DMEPOS table).

                                        CODES:
                                          REFER TO: NCH_CLM_TYPE_TB
                                                    IN THE CODES APPENDIX

                                        SOURCE:
                                        NCH

      6. Claim Diagnosis Code         CHAR     5   22   26   The ICD-9-CM based code identifying the
                                                            beneficiary's principal or other diagnosis
                                                            (including E code).

                                        NOTE:
                                        Prior to Version H, the principal diagnosis
                                        code was not stored with the 'OTHER' diagnosis
                                        codes.  During the Version H conversion the
                                        CLM_PRNCPAL_DGNS_CD was added as the first
                                        occurrence.

                                        DB2 ALIAS: CLM_DGNS_CD
                                        SAS ALIAS: DGNS_CD
                                        STANDARD ALIAS: CLM_DGNS_CD
                                        TITLE ALIAS: DIAGNOSIS
```

```
                                  POSITIONS
             NAME              TYPE  LENGTH BEG  END                          CONTENTS
   -------------------------  ----  ------ --------  ----------------------------------------------------------

                                        EDIT-RULES:
                                        ICD-9-CM

                                        COMMENT:
                                        Prior to Version H this field was named:
                                        CLM_OTHR_DGNS_CD.
```

```
   ********************************************************************************************************

              C L A I M   R E L A T E D   C O N D I T I O N   G R O U P   R E C O R D

   ********************************************************************************************************


                                  POSITIONS
             NAME              TYPE  LENGTH BEG  END                          CONTENTS
```

```
       --------------------------  ----  ------ ---------  --------------------------------------------------------------
****   FI HHA Claim               GROUP   23               Claim Related Condition Group Record
       Related Condition Group                             for the Encrypted Standard View of the
       Record - Encrypted                                  HHA version I NCH Nearline File.
       Standard View
                                                           The number of claim related condition
                                                           trailers is determined by the claim related
                                                           condition code count. Effective 10/93,
                                                           up to 30 occurrences can be reported on an
                                                           institutional claim. Prior to 10/93, up
                                                           to 10 occurrences could be reported.


                                                           OCCURS: UP TO 30 TIMES
                                                                   DEPENDING ON HHA_CLM_RLT_COND_CD_CNT

                                                           STANDARD ALIAS: UTLHHAI_CLM_RLT_COND_GRP


   1. Record Length Count         NUM      5    1    5     The length of the Claim Related Condition Group
                                                           Record.

                                                           5 DIGITS UNSIGNED

                                                           STANDARD ALIAS: TRAIL_BYTE_COUNT


   2. Record Number               NUM      9    6   14     A sequentially assigned number for the claims included
                                                           in the file. This number allows the user to link all of
                                                           the records associated with one claim.

                                                           STANDARD ALIAS: TRAIL_CLAIM_NO


   3. Record Type                 NUM      2   15   16     Type of Record.

                                                           STANDARD ALIAS: TRAIL_REC_TYPE


                                                           CODES:
                                                           00 = Fixed/Main Group
                                                           01 = Carrier Line Group
                                                           02 = Claim Demonstration ID Group
                                                           03 = Claim Diagnosis Group
                                                           04 = Claim Health PlanID Group
                                                           05 = Claim Occurrence Span Group
                                                           06 = Claim Procedure Group
                                                           07 = Claim Related Condition Group
                                                           08 = Claim Related Occurrence Group
                                                           09 = Claim Value Group
```

```
                                     POSITIONS
                NAME              TYPE LENGTH BEG  END                              CONTENTS
       --------------------------  ----  ------ ---------  --------------------------------------------------------------
                                                           10 = MCO Period Group
                                                           11 = NCH Edit Group
                                                           12 = NCH Patch Group
                                                           13 = DMERC Line Group
```

```
                                14 = Revenue Center Group

4. Claim Sequence Number      NUM    3   17   19   A counter for records that consist of trailer
                                                   information, such as claim line and revenue center
                                                   data, which can occur multiple times for one claim.

                                                   STANDARD ALIAS: TRAIL_CLAIM_SEQ

5. NCH Claim Type Code        CHAR   2   20   21   The code used to identify the type of claim record being
                                                   processed in NCH.

                                                   NOTE1:   During the Version H conversion this field was
                                                            populated with data through- out history (back to
                                                            service year 1991).

                                                   NOTE2:   During the Version I conversion this field was
                                                            expanded to include inpatient 'full' encounter
                                                            claims (for service dates after 6/30/97).
                                                            Placeholders for Physician and Outpatient encounters
                                                            (available in NMUD) have also been added.

                                                   STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                                                   DERIVATION:
                                                   FFS CLAIM TYPE CODES DERIVED FROM:
                                                     NCH CLM_NEAR_LINE_RIC_CD
                                                     NCH PMT_EDIT_RIC_CD
                                                     NCH CLM_TRANS_CD
                                                     NCH PRVDR_NUM

                                                   INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                     (Pre-HDC processing -- AVAILABLE IN NCH)
                                                     CLM_MCO_PD_SW
                                                     CLM_RLT_COND_CD
                                                     MCO_CNTRCT_NUM
                                                     MCO_OPTN_CD
                                                     MCO_PRD_EFCTV_DT
                                                     MCO_PRD_TRMNTN_DT

                                                   INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                     (HDC processing -- AVAILABLE IN NMUD)
                                                     FI_NUM

                                                   INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                   FROM: (HDC processing -- AVAILABLE IN NMUD)
                                                     FI_NUM
                                                     CLM_FAC_TYPE_CD
                                                     CLM_SRVC_CLSFCTN_TYPE_CD
                                                     CLM_FREQ_CD
```

```
                              POSITIONS
            NAME           TYPE  LENGTH BEG  END                              CONTENTS
 -------------------------  ----  ------ ---------  -------------------------------------------------------------

                                                   NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                   abbreviated inpatient encounter claims are not
```

available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  CARR_NUM
  CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM: (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
  FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
  2.   PMT_EDIT_RIC_CD EQUAL 'F'
  3.   CLM_TRANS_CD EQUAL '5'

  SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
  2.   PMT_EDIT_RIC_CD EQUAL 'D'
  3.   CLM_TRANS_CD EQUAL '6'

  SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
  ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
  THE FOLLOWING CONDITIONS ARE MET:

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

```
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2.    PMT_EDIT_RIC_CD EQUAL 'D'
3.    CLM_TRANS_CD EQUAL '6'
4.    FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1.    FI_NUM = 80881
2.    CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
      CLSFCTN_TYPE_CD = '2', '3' OR '4' &
      CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.    PMT_EDIT_RIC_CD EQUAL 'I'
3.    CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_MCO_PD_SW = '1'
2.    CLM_RLT_COND_CD = '04'
3.    MCO_CNTRCT_NUM
      MCO_OPTN_CD = 'C'
      CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
      MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
      ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.    FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.    FI_NUM = 80881 AND
2.    CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
      TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.    HCPCS_CD not on DMEPOS table
```

```
           NAME                  TYPE   LENGTH BEG   END                      CONTENTS
-------------------------    ----  ------  --------  ----------------------------------------------------------
                                                  SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                                  WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                                  2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                         more line item(s) match the HCPCS on the
                                                         DMEPOS table).

                                                  SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                                  EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                                  CONDITIONS ARE MET:
                                                  1.   CARR_NUM = 80882 AND
                                                  2.   CLM_DEMO_ID_NUM = 38

                                                  SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                                     CLAIM)
                                                  WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                  2.   HCPCS_CD not on DMEPOS table

                                                  SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                                  WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                  2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                         more line item(s) match the HCPCS on the
                                                         DMEPOS table).

                                                  CODES:
                                                    REFER TO: NCH_CLM_TYPE_TB
                                                              IN THE CODES APPENDIX

                                                  SOURCE:
                                                  NCH

   6. Claim Related Condition     CHAR     2    22   23  The code that indicates a condition relating to
      Code                                                an institutional claim that may affect payer
                                                          processing.

                                                  DB2 ALIAS: CLM_RLT_COND_CD
                                                  SAS ALIAS: RLT_COND
                                                  STANDARD ALIAS: CLM_RLT_COND_CD
                                                  SYSTEM ALIAS: LTCOND
                                                  TITLE ALIAS: RELATED_CONDITION_CD

                                                  CODES:
                                                  01 THRU 16 = Insurance related
                                                  17 THRU 30 = Special condition
                                                  31 THRU 35 = Student status codes which are required
                                                               when a patient is a dependent child
                                                               over 18 years old
                                                  36 THRU 45 = Accommodation
                                                  46 THRU 54 = CHAMPUS information
```

```
                                         POSITIONS
           NAME                  TYPE   LENGTH BEG   END                      CONTENTS
```

```
-------------------------- ---- ------ --------  -----------------------------------------------------------
                                                 55 THRU 59 = Skilled nursing facility
                                                 60 THRU 70 = Prospective payment
                                                 71 THRU 99 = Renal dialysis setting
                                                 A0 THRU B9 = Special program codes
                                                 C0 THRU C9 = PRO approval services
                                                 D0 THRU W0 = Change conditions

                                                 CODES:
                                                   REFER TO: CLM_RLT_COND_TB
                                                                IN THE CODES APPENDIX

                                                 SOURCE:
                                                 CWF
```

1   FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
*****************************************************************************************************

          C L A I M    R E L A T E D    O C C U R R E N C E    G R O U P    R E C O R D

*****************************************************************************************************

                                     POSITIONS
            NAME               TYPE  LENGTH BEG  END                       CONTENTS
-------------------------- ---- ------ --------  -----------------------------------------------------------
**** FI HHA Claim Related    GROUP   31            Claim Related Occurrence Group Record
     Occurrence Group                              for the Encrypted Standard View of the
     Record - Encrypted                            HHA version I NCH Nearline File.
     Standard View
                                                   The number of claim related occurrence
                                                   trailers is determined by the claim related
                                                   occurrence code count. Effective 10/93,
                                                   up to 30 occurrences can be reported on an
                                                   institutional claim. Prior to 10/93, up
                                                   to 10 occurrences could be reported.


                                                   OCCURS: UP TO 30 TIMES
                                                           DEPENDING ON HHA_CLM_RLT_OCRNC_CD_CNT

                                                   STANDARD ALIAS: UTLHHAI_CLM_RLT_OCRNC_GRP


  1. Record Length Count      NUM     5   1    5   The length of the Claim Related Occurrence Group.

                                                   5 DIGITS UNSIGNED

                                                   STANDARD ALIAS: TRAIL_BYTE_COUNT

  2. Record Number            NUM     9   6   14   A sequentially assigned number for the claims included
                                                   in the file. This number allows the user to link all of
                                                   the records associated with one claim.

                                                   STANDARD ALIAS: TRAIL_CLAIM_NO
```

```
      3. Record Type                NUM      2    15   16   Type of Record.

                                                            STANDARD ALIAS: TRAIL_REC_TYPE

                                                            CODES:
                                                            00 = Fixed/Main Group
                                                            01 = Carrier Line Group
                                                            02 = Claim Demonstration ID Group
                                                            03 = Claim Diagnosis Group
                                                            04 = Claim Health PlanID Group
                                                            05 = Claim Occurrence Span Group
                                                            06 = Claim Procedure Group
                                                            07 = Claim Related Condition Group
                                                            08 = Claim Related Occurrence Group
                                                            09 = Claim Value Group
                                                            10 = MCO Period Group
                                                            11 = NCH Edit Group
                                                            12 = NCH Patch Group
1           FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                       POSITIONS
                    NAME              TYPE  LENGTH BEG  END                         CONTENTS
          -------------------------   ----  ------ ---------   ------------------------------------------------------------

                                                            13 = DMERC Line Group
                                                            14 = Revenue Center Group

      4. Claim Sequence Number       NUM      3    17   19   A counter for records that consist of trailer
                                                            information, such as claim line and revenue center
                                                            data, which can occur multiple times for one claim.

                                                            STANDARD ALIAS: TRAIL_CLAIM_SEQ

      5. NCH Claim Type Code         CHAR     2    20   21   The code used to identify the type of claim record being
                                                            processed in NCH.

                                                            NOTE1:  During the Version H conversion this field was
                                                                    populated with data through- out history (back to
                                                                    service year 1991).

                                                            NOTE2:  During the Version I conversion this field was
                                                                    expanded to include inpatient 'full' encounter
                                                                    claims (for service dates after 6/30/97).
                                                                    Placeholders for Physician and Outpatient encounters
                                                                    (available in NMUD) have also been added.

                                                            STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                                                            DERIVATION:
                                                            FFS CLAIM TYPE CODES DERIVED FROM:
                                                              NCH CLM_NEAR_LINE_RIC_CD
                                                              NCH PMT_EDIT_RIC_CD
                                                              NCH CLM_TRANS_CD
                                                              NCH PRVDR_NUM

                                                            INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                              (Pre-HDC processing -- AVAILABLE IN NCH)
                                                              CLM_MCO_PD_SW
```

```
                           CLM_RLT_COND_CD
                           MCO_CNTRCT_NUM
                           MCO_OPTN_CD
                           MCO_PRD_EFCTV_DT
                           MCO_PRD_TRMNTN_DT


                           INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                             (HDC processing -- AVAILABLE IN NMUD)
                             FI_NUM


                           INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                           FROM: (HDC processing -- AVAILABLE IN NMUD)
                             FI_NUM
                             CLM_FAC_TYPE_CD
                             CLM_SRVC_CLSFCTN_TYPE_CD
                             CLM_FREQ_CD
                           NOTE:  From 7/1/97 to the start of HDC processing(?),
                           abbreviated inpatient encounter claims are not
                           available in NCH or NMUD.
```

1   FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                       POSITIONS
                NAME            TYPE  LENGTH BEG  END                          CONTENTS
        -------------------------   ----  ------ ---------  ------------------------------------------------------------

                           PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                             (AVAILABLE IN NMUD)
                             CARR_NUM
                             CLM_DEMO_ID_NUM

                           OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                             (AVAILABLE IN NMUD)
                             FI_NUM

                           OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                           DERIVED FROM:  (AVAILABLE IN NMUD)
                             FI_NUM
                             CLM_FAC_TYPE_CD
                             CLM_SRVC_CLSFCTN_TYPE_CD
                             CLM_FREQ_CD

                           DERIVATION RULES:

                             SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                             FOLLOWING CONDITIONS ARE MET:
                             1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                             2.   PMT_EDIT_RIC_CD EQUAL 'F'
                             3.   CLM_TRANS_CD EQUAL '5'

                             SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                             WHERE THE FOLLOWING CONDITIONS ARE MET:
                             1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                             2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                             3.   CLM_TRANS_CD EQUAL '0' OR '4'
                             4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                  OR 'Z'
```

```
                    SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                    3.   CLM_TRANS_CD EQUAL '0' OR '4'
                    4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                         OR 'Z'

                    SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'

                    SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                    ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                    THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'
                    4.   FI_NUM = 80881
```

```
                                    POSITIONS
         NAME               TYPE  LENGTH BEG  END                              CONTENTS
------------------------    ----  ------ ---------  ------------------------------------------------------------
                    SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                    ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                    1.   FI_NUM = 80881
                    2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                         CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                         CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                    SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'I'
                    3.   CLM_TRANS_CD EQUAL 'H'

                    SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                    3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                    SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                    CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                    12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_MCO_PD_SW = '1'
                    2.   CLM_RLT_COND_CD = '04'
                    3.   MCO_CNTRCT_NUM
                         MCO_OPTN_CD = 'C'
                         CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                         MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                         ENROLLMENT PERIODS
```

```
                              SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                              CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                              FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                              2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                              3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                              4.   FI_NUM = 80881

                              SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                              ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                              THE FOLLOWING CONDITIONS ARE MET:
                              1.   FI_NUM = 80881 AND
                              2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                                   TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                              SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                              2.   HCPCS_CD not on DMEPOS table
```

1   FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                          POSITIONS
              NAME                TYPE  LENGTH BEG  END                    CONTENTS
-------------------------         ----  ------ ---------   --------------------------------------------------------
```

```
                              SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                              2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                     more line item(s) match the HCPCS on the
                                     DMEPOS table).

                              SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                              EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                              CONDITIONS ARE MET:
                              1.   CARR_NUM = 80882 AND
                              2.   CLM_DEMO_ID_NUM = 38

                              SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                 CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                              2.   HCPCS_CD not on DMEPOS table

                              SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                              2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                     more line item(s) match the HCPCS on the
                                     DMEPOS table).

                          CODES:
                            REFER TO: NCH_CLM_TYPE_TB
                                       IN THE CODES APPENDIX

                          SOURCE:
                          NCH
```

```
6. Claim Related Occurrence      CHAR     2   22   23   The code that identifies a significant event
   Code                                                 relating to an institutional claim that may
                                                        affect payer processing.  These codes are
                                                        claim-related occurrences that are related
                                                        to a specific date.

                                                        DB2 ALIAS: CLM_RLT_OCRNC_CD
                                                        SAS ALIAS: OCRNC_CD
                                                        STANDARD ALIAS: CLM_RLT_OCRNC_CD
                                                        SYSTEM ALIAS: LTOCRNC
                                                        TITLE ALIAS: OCCURRENCE_CD

                                                        CODES:
                                                        01 THRU 09 = Accident
                                                        10 THRU 19 = Medical condition
                                                        20 THRU 39 = Insurance related
                                                        40 THRU 69 = Service related
                                                        A1-A3 = Miscellaneous
```

```
                                      POSITIONS
            NAME               TYPE  LENGTH BEG  END                       CONTENTS
-------------------------      ----  ------ ---------  --------------------------------------------------------

                                                        CODES:
                                                           REFER TO: CLM_RLT_OCRNC_TB
                                                                        IN THE CODES APPENDIX

                                                        SOURCE:
                                                        CWF

7. Claim Related Occurrence      NUM     8   24   31   The date associated with a significant event
   Date                                                related to an institutional claim that may
                                                       affect payer processing.

                                                       For the ENCRYPTED Standard View of the
                                                       HHA files, the claim related occurrence
                                                       date is coded as the quarter of the
                                                       calendar year when the related
                                                       occurrence occurred.

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: CLM_RLT_OCRNC_DT
                                                       SAS ALIAS: OCRNCDT
                                                       STANDARD ALIAS: CLM_RLT_OCRNC_DT
                                                       TITLE ALIAS: RLT_OCRNC_DT

                                                       EDIT-RULES FOR ENCRYPTED DATA:
                                                       YYYYQ000 WHERE Q IS ONE OF THE
                                                       FOLLOWING VALUES.
                                                       1 = FIRST QUARTER OF THE CALENDAR YEAR
                                                       2 = SECOND QUARTER OF THE CALENDAR YEAR
                                                       3 = THIRD QUARTER OF THE CALENDAR YEAR
                                                       4 = FOURTH QUARTER OF THE CALENDAR YEAR
```

```
*******************************************************************************************

               C L A I M    V A L U E    G R O U P    R E C O R D

*******************************************************************************************
```

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
****	FI HHA Claim Value Group Record - Encrypted Standard View	GROUP	36			Claim Value Group Record for the Encrypted Standard View of the HHA version I NCH Nearline File.

The number of claim value data trailers present is determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

OCCURS: UP TO 36 TIMES
          DEPENDING ON HHA_CLM_VAL_CD_CNT

STANDARD ALIAS: UTLHHAI_CLM_VAL_GRP

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
1.	Record Length Count	NUM	5	1	5	The length of the Claim Value Group Record.

5 DIGITS UNSIGNED

STANDARD ALIAS: TRAIL_BYTE_COUNT

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
2.	Record Number	NUM	9	6	14	A sequentially assigned number for the claims included in the file. This number allows the user to link all of the records associated with one claim.

STANDARD ALIAS: TRAIL_CLAIM_NO

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
3.	Record Type	NUM	2	15	16	Type of Record.

STANDARD ALIAS: TRAIL_REC_TYPE

CODES:
00 = Fixed/Main Group
01 = Carrier Line Group
02 = Claim Demonstration ID Group
03 = Claim Diagnosis Group
04 = Claim Health PlanID Group
05 = Claim Occurrence Span Group

```
                                      06 = Claim Procedure Group
                                      07 = Claim Related Condition Group
                                      08 = Claim Related Occurrence Group
                                      09 = Claim Value Group
                                      10 = MCO Period Group
```

1   FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                      POSITIONS
               NAME              TYPE  LENGTH BEG  END                        CONTENTS
    --------------------------   ----  ------ ---------   ------------------------------------------------------------
```

```
                                      11 = NCH Edit Group
                                      12 = NCH Patch Group
                                      13 = DMERC Line Group
                                      14 = Revenue Center Group
```

```
    4. Claim Sequence Number      NUM     3    17   19   A counter for records that consist of trailer
                                                         information, such as claim line and revenue center
                                                         data, which can occur multiple times for one claim.

                                                         STANDARD ALIAS: TRAIL_CLAIM_SEQ

    5. NCH Claim Type Code        CHAR    2    20   21   The code used to identify the type of claim record being
                                                         processed in NCH.

                                                         NOTE1:  During the Version H conversion this field was
                                                                 populated with data through- out history (back to
                                                                 service year 1991).

                                                         NOTE2:  During the Version I conversion this field was
                                                                 expanded to include inpatient 'full' encounter
                                                                 claims (for service dates after 6/30/97).
                                                                 Placeholders for Physician and Outpatient encounters
                                                                 (available in NMUD) have also been added.

                                                         SYSTEM ALIAS: TRAIL_NCH_CLM_TYPE_CD

                                                         DERIVATION:
                                                         FFS CLAIM TYPE CODES DERIVED FROM:
                                                           NCH CLM_NEAR_LINE_RIC_CD
                                                           NCH PMT_EDIT_RIC_CD
                                                           NCH CLM_TRANS_CD
                                                           NCH PRVDR_NUM

                                                         INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                           (Pre-HDC processing -- AVAILABLE IN NCH)
                                                           CLM_MCO_PD_SW
                                                           CLM_RLT_COND_CD
                                                           MCO_CNTRCT_NUM
                                                           MCO_OPTN_CD
                                                           MCO_PRD_EFCTV_DT
                                                           MCO_PRD_TRMNTN_DT

                                                         INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                           (HDC processing -- AVAILABLE IN NMUD)
                                                           FI_NUM
```

```
                                 INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                 FROM: (HDC processing -- AVAILABLE IN NMUD)
                                   FI_NUM
                                   CLM_FAC_TYPE_CD
                                   CLM_SRVC_CLSFCTN_TYPE_CD
                                   CLM_FREQ_CD

1        FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002


                                 POSITIONS
                NAME             TYPE  LENGTH BEG  END                            CONTENTS
      -------------------------  ----  ------ ---------  -------------------------------------------------------------
                                                         NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                         abbreviated inpatient encounter claims are not
                                                         available in NCH or NMUD.

                                                         PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                           (AVAILABLE IN NMUD)
                                                           CARR_NUM
                                                           CLM_DEMO_ID_NUM

                                                         OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                           (AVAILABLE IN NMUD)
                                                           FI_NUM

                                                         OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                         DERIVED FROM:  (AVAILABLE IN NMUD)
                                                           FI_NUM
                                                           CLM_FAC_TYPE_CD
                                                           CLM_SRVC_CLSFCTN_TYPE_CD
                                                           CLM_FREQ_CD

                                                         DERIVATION RULES:

                                                           SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                           FOLLOWING CONDITIONS ARE MET:
                                                           1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                           2.   PMT_EDIT_RIC_CD EQUAL 'F'
                                                           3.   CLM_TRANS_CD EQUAL '5'

                                                           SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                           WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                           1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                           2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                           3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                           4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                                                OR 'Z'

                                                           SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                                                           WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                           1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                           2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                           3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                           4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                                                OR 'Z'

                                                           SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
```

```
                                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                   2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                   3.   CLM_TRANS_CD EQUAL '6'

                                   SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                   ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                   THE FOLLOWING CONDITIONS ARE MET:
```

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```
                         POSITIONS
           NAME           TYPE  LENGTH BEG  END                    CONTENTS
-------------------------  ----  ------ ---------  --------------------------------------------------------
                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                   2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                   3.   CLM_TRANS_CD EQUAL '6'
                                   4.   FI_NUM = 80881

                                   SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                   ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                   1.   FI_NUM = 80881
                                   2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                        CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                        CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                                   SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                   2.   PMT_EDIT_RIC_CD EQUAL 'I'
                                   3.   CLM_TRANS_CD EQUAL 'H'

                                   SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                   2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                   3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                                   SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                   CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                                   12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                                   1.   CLM_MCO_PD_SW = '1'
                                   2.   CLM_RLT_COND_CD = '04'
                                   3.   MCO_CNTRCT_NUM
                                        MCO_OPTN_CD = 'C'
                                        CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                                        MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                        ENROLLMENT PERIODS

                                   SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                   CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                                   FOLLOWING CONDITIONS ARE MET:
                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                   2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                   3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                                   4.   FI_NUM = 80881
```

```
                                         SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                                         ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                         THE FOLLOWING CONDITIONS ARE MET:
                                         1.   FI_NUM = 80881 AND
                                         2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                                                 TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                                         SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                         2.   HCPCS_CD not on DMEPOS table
```

```
                                    POSITIONS
               NAME            TYPE  LENGTH BEG  END                        CONTENTS
     -------------------------  ----  ------ --------  -------------------------------------------------------------
```

```
                                         SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                         2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                 more line item(s) match the HCPCS on the
                                                 DMEPOS table).

                                         SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                         EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                         CONDITIONS ARE MET:
                                         1.   CARR_NUM = 80882 AND
                                         2.   CLM_DEMO_ID_NUM = 38

                                         SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                            CLAIM)
                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                         2.   HCPCS_CD not on DMEPOS table

                                         SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                         2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                 more line item(s) match the HCPCS on the
                                                 DMEPOS table).

                                         CODES:
                                           REFER TO: NCH_CLM_TYPE_TB
                                                      IN THE CODES APPENDIX

                                         SOURCE:
                                         NCH

     6. Claim Value Code          CHAR    2    22   23  The code indicating the value of a monetary
                                                        condition which was used by the intermediary
                                                        to process an institutional claim.

                                                        DB2 ALIAS: CLM_VAL_CD
                                                        SAS ALIAS: VAL_CD
                                                        STANDARD ALIAS: CLM_VAL_CD
```

```
                                SYSTEM ALIAS: LTVALUE
                                TITLE ALIAS: VALUE_CD


                                CODES:
                                  REFER TO: CLM_VAL_TB
                                            IN THE CODES APPENDIX


                                SOURCE:
                                CWF

      7. Claim Value Amount         CHAR    13    24   36   The amount related to the condition identified
                                                           in the CLM_VAL_CD which was used by the
                                                           intermediary to process the institutional
                                                           claim.

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                                              POSITIONS
                NAME               TYPE  LENGTH BEG  END                        CONTENTS
      --------------------------   ----  ------ ---------  --------------------------------------------------------


                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: CLM_VAL_AMT
                                                           SAS ALIAS: VAL_AMT
                                                           STANDARD ALIAS: CLM_VAL_AMT
                                                           TITLE ALIAS: VALUE_AMOUNT


                                                           EDIT-RULES:
                                                           +9(9).99


                                                           SOURCE:
                                                           CWF

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      ********************************************************************************************************

                C L A I M   R E V E N U E   C E N T E R   G R O U P   R E C O R D

      ********************************************************************************************************


                                              POSITIONS
                NAME               TYPE  LENGTH BEG  END                        CONTENTS
      --------------------------   ----  ------ ---------  --------------------------------------------------------
 ****  FI HHA Claim Revenue        GROUP   262               Claim Revenue Center Group Record
       Center Group Record -                                 for the Encrypted Standard View of the
       Encrypted Standard View                               HHA version I Nearline File.

                                                           The number of claim revenue center group
                                                           trailers present is determined by the claim
                                                           revenue center code count. Effective 7/7/00,
                                                           up to 450 occurrences may be reported for an
                                                           institutional claim. The increase in the number
                                                           of revenue center lines causes each claim to
                                                           be broken out into records/segments (up to 10).
```

Each record can have up to 45 occurrences of
revenue center lines. Prior to 7/7/00, up to
58 occurrences may be reported on an institutional
claim. Claims submitted prior to 10/93, contained
up to 28 occurrences.

OCCURS: UP TO 45 TIMES
        DEPENDING ON HHA_REV_CNTR_CD_I_CNT

STANDARD ALIAS: UTLHHAI_CLM_REV_CNTR_GRP

COMMENT:
****************** FOR SNF PPS *********************
The Balanced Budget Act modified how payment will be
made for skilled nursing facility (SNF) services.
Effective with cost reporting periods beginning on or
after 7/1/98 (with all providers transitioning by
6/30/99, SNFs will be paid on a prospective payment
system (PPS).

SNFs will classify beneficiaries on the basis of
residents' characteristics and resource needs, using
the 44-group patient classification system known as
Resource Utilization Groups (RUGS), Version III.
Facilities will use information from the Minimum Data
Set (MDS), Version 2.0, Resident Assessment Instrument
(RAI) to classify residents into the RUG-III groups.

***************** FOR OUTPATIENT PPS ***************
The Balanced Budget Act modified how payment will be
made for hospital outpatient services, certain PTB
services furnished to inpatients who have no PTA
coverage, CMHCs, and limited services provided by
CORFs, Home Health Agencies or to hospice patients
for the treatment of a non-terminal illness. Imple-

```
                              POSITIONS
         NAME            TYPE  LENGTH BEG  END                         CONTENTS
-------------------------  ----  ------ ---------  -------------------------------------------------------------
```

mentation for Outpatient PPS (OPPS) will be effective
for claims with dates of service on or after
July 1, 2000.

Payment for services under the OPPS system is
calculated based on grouping outpatient services
into ambulatory payment classifications (APC) groups.

************** FOR HOME HEALTH PPS ***************
The Balanced Budget Act of 1997 mandated changes in
payment and other provider requirements for home
health. All home health agencies will be paid
through a prospective payment system beginning
October 1, 2000.

Under Home Health PPS (HH PPS) the unit of payment

```
                                      will be a 60-day episode.  Home Health Resources
                                      Groups (HHRGs), also called HRGs represented by
                                      HCFA HIPPS coding, will be the basis of payment for
                                      each episode; HHRGs will be produced through pubicly
                                      available Grouper software that will determine the
                                      appropriate HHRG when results of comprehensive
                                      assessments of the beneficiary (made incorporating
                                      the OASIS data set) are input or grouped in this
                                      software.

  1. Record Length Count        NUM      5    1    5  The length of the Claim Revenue Center Group
                                                      Record.

                                                      5 DIGITS UNSIGNED

                                                      STANDARD ALIAS: TRAIL_BYTE_COUNT

  2. Record Number              NUM      9    6   14  An sequentially assigned number for the claims included
                                                      in the file. This number allows the user to link all of
                                                      the records associated with one claim.

                                                      STANDARD ALIAS: TRAIL_CLAIM_NO

  3. Record Type                NUM      2   15   16  Type of Record.

                                                      STANDARD ALIAS: TRAIL_REC_TYPE

                                                      CODES:
                                                      00 = Fixed/Main Group
                                                      01 = Carrier Line Group
                                                      02 = Claim Demonstration ID Group
                                                      03 = Claim Diagnosis Group
                                                      04 = Claim Health PlanID Group
                                                      05 = Claim Occurrence Span Group
                                                      06 = Claim Procedure Group
                                                      07 = Claim Related Condition Group
                                                      08 = Claim Related Occurrence Group
```

```
                                      POSITIONS
                    NAME          TYPE LENGTH BEG  END                         CONTENTS
          -------------------------- ---- ------ --------- --------------------------------------------------------
                                                      09 = Claim Value Group
                                                      10 = MCO Period Group
                                                      11 = NCH Edit Group
                                                      12 = NCH Patch Group
                                                      13 = DMERC Line Group
                                                      14 = Revenue Center Group

  4. Claim Sequence Number      NUM      3   17   19  A counter for records that consist of trailer
                                                      information, such as claim line and revenue center
                                                      data, which can occur multiple times for one claim.

                                                      STANDARD ALIAS: TRAIL_CLAIM_SEQ

  5. NCH Claim Type Code        CHAR     2   20   21  The code used to identify the type of claim record being
```

processed in NCH.

NOTE1: During the Version H conversion this field was
        populated with data through- out history (back to
        service year 1991).

NOTE2: During the Version I conversion this field was
        expanded to include inpatient 'full' encounter
        claims (for service dates after 6/30/97).
        Placeholders for Physician and Outpatient encounters
        (available in NMUD) have also been added.

STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH CLM_NEAR_LINE_RIC_CD
  NCH PMT_EDIT_RIC_CD
  NCH CLM_TRANS_CD
  NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (Pre-HDC processing -- AVAILABLE IN NCH)
  CLM_MCO_PD_SW
  CLM_RLT_COND_CD
  MCO_CNTRCT_NUM
  MCO_OPTN_CD
  MCO_PRD_EFCTV_DT
  MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
FROM: (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

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                            POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
-------------------------- ---- ------ -------- ---

                                                 NOTE: From 7/1/97 to the start of HDC processing(?),
                                                 abbreviated inpatient encounter claims are not
                                                 available in NCH or NMUD.

                                                 PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                   (AVAILABLE IN NMUD)
                                                   CARR_NUM
                                                   CLM_DEMO_ID_NUM

                                                 OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                   (AVAILABLE IN NMUD)

```
                             FI_NUM

                 OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                 DERIVED FROM:  (AVAILABLE IN NMUD)
                   FI_NUM
                   CLM_FAC_TYPE_CD
                   CLM_SRVC_CLSFCTN_TYPE_CD
                   CLM_FREQ_CD

                 DERIVATION RULES:

                   SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                   FOLLOWING CONDITIONS ARE MET:
                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                   2.   PMT_EDIT_RIC_CD EQUAL 'F'
                   3.   CLM_TRANS_CD EQUAL '5'

                   SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                   2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                   3.   CLM_TRANS_CD EQUAL '0' OR '4'
                   4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                        OR 'Z'
                   SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                   2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                   3.   CLM_TRANS_CD EQUAL '0' OR '4'
                   4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                        OR 'Z'

                   SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                   2.   PMT_EDIT_RIC_CD EQUAL 'D'
                   3.   CLM_TRANS_CD EQUAL '6'

                   SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                   ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                   THE FOLLOWING CONDITIONS ARE MET:
```

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```
                              POSITIONS
             NAME            TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------- ----  ------ ---------  ----------------------------------------------------------
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                      2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                      3.   CLM_TRANS_CD EQUAL '6'
                                                      4.   FI_NUM = 80881

                                                      SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                                      ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                                      1.   FI_NUM = 80881
                                                      2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                                           CLSFCTN_TYPE_CD = '2', '3' OR '4' &
```

```
                    CLM_FREQ_CD = 'Z', 'Y' OR 'X'

          SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
          WHERE THE FOLLOWING CONDITIONS ARE MET:
          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
          2.   PMT_EDIT_RIC_CD EQUAL 'I'
          3.   CLM_TRANS_CD EQUAL 'H'

          SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
          WHERE THE FOLLOWING CONDITIONS ARE MET:
          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
          2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
          3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

          SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
          CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
          12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
          1.   CLM_MCO_PD_SW = '1'
          2.   CLM_RLT_COND_CD = '04'
          3.   MCO_CNTRCT_NUM
               MCO_OPTN_CD = 'C'
               CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
               MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
               ENROLLMENT PERIODS

          SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
          CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
          FOLLOWING CONDITIONS ARE MET:
          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
          2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
          3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
          4.   FI_NUM = 80881

          SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
          ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
          THE FOLLOWING CONDITIONS ARE MET:
          1.   FI_NUM = 80881 AND
          2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
               TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

          SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
          WHERE THE FOLLOWING CONDITIONS ARE MET:
          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
          2.   HCPCS_CD not on DMEPOS table
```

```
                            POSITIONS
          NAME               TYPE  LENGTH BEG  END                          CONTENTS
-------------------------  ----  ------ ---------  -------------------------------------------------------------

                                              SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                              2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                     more line item(s) match the HCPCS on the
                                                     DMEPOS table).
```

```
                              SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                              EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                              CONDITIONS ARE MET:
                              1.   CARR_NUM = 80882 AND
                              2.   CLM_DEMO_ID_NUM = 38

                              SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                 CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                              2.   HCPCS_CD not on DMEPOS table

                              SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                              2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                    more line item(s) match the HCPCS on the
                                    DMEPOS table).

                              CODES:
                                REFER TO: NCH_CLM_TYPE_TB
                                          IN THE CODES APPENDIX

                              SOURCE:
                              NCH


    6. Revenue Center Code        CHAR    4   22   25  The provider-assigned revenue code for each cost center for
                                                       which a separate charge is billed (type of accommodation or
                                                       ancillary).  A cost center is a division or unit within a
                                                       hospital (e.g., radiology, emergency room, pathology).
                                                       EXCEPTION:  Revenue center code 0001 represents the total of
                                                       all revenue centers included on the claim.

                              COBOL ALIAS: REV_CD
                              DB2 ALIAS: REV_CNTR_CD
                              SAS ALIAS: REV_CNTR
                              STANDARD ALIAS: REV_CNTR_CD
                              SYSTEM ALIAS: LTRC
                              TITLE ALIAS: REVENUE_CENTER_CD

                              CODES:
                                REFER TO: REV_CNTR_TB
                                          IN THE CODES APPENDIX

                              SOURCE:
                              CWF
```

```
                                     POSITIONS
              NAME              TYPE  LENGTH BEG  END                     CONTENTS
    --------------------------  ----  ------ --------  ----------------------------------------------------------

    7. Revenue Center Date        NUM     8   26   33  Effective with Version H, the date applicable
                                                       to the service represented by the revenue center
                                                       code.   This field may be present on any of the
                                                       institutional claim types.  For home health claims
                                                       the service date should be present on all bills
```

with from date greater than 3/31/98. With the
implementation of outpatient PPS, hospitals will
be required to enter line item dates of service
for all outpatient services which require a HCPCS.

For the ENCRYPTED Standard View of the HHA
files, the date applicable to the service
represented by the revenue center code is
coded as the quarter of the calendar year
when the service represented by the revenue
center code occurred.

NOTE1: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain
zeroes in this field.

NOTE2: When revenue center code equals '0022'
(SNF PPS) and revenue center HCPCS code not equal
to 'AAA00' (default for no assessment), date re-
presents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023'
(HHPPS), the date on the initial claim (RAP) must
represent the first date of service in the episode.
The final claim will match the '0023' information
submitted on the initial claim. The SCIC
(significant change in condition) claims may show
additional '0023' revenue lines in which the
date represents the date of the first service
under the revised plan of treatment.

8 DIGITS UNSIGNED

DB2 ALIAS: REV_CNTR_DT
SAS ALIAS: REV_DT
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE

EDIT-RULES FOR ENCRYPTED DATA:
YYYYQ000 WHERE Q IS ONE OF THE
FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					SOURCE:
					CWF
8. Revenue Center APC/HIPPS	CHAR	5	34	38	Effective with Outpatient PPS (OPPS), the Ambulatory
Code					Payment Classification (APC) code used to identify

```
                                      groupings of outpatient services.  APC codes are
                                      used to calculate payment for services under
                                      OPPS.

                                      Effective with Home Health PPS (HHPPS), this field
                                      will only be populated with a HIPPS code if the HIPPS
                                      code that is stored in the HCPCS field has been
                                      downcoded and the new code will be placed in this
                                      field.

                                      NOTE1: Under SNF PPS and HHPPS, HIPPS codes are
                                      stored in the HCPCS field. **EXCEPTION: if a
                                      HHPPS HIPPS code is downcoded the downcoded
                                      HIPPS will be stored in this field.

                                      NOTE2:  Beginning with NCH weekly process date
                                      8/18/00, this field will be populated with data.
                                      Claims processed prior to 8/18/00 will contain
                                      spaces in this field.

                                      DB2 ALIAS: REV_APC_HIPPS_CD
                                      SAS ALIAS: APCHIPPS
                                      STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
                                      SYSTEM ALIAS: LTAPC
                                      TITLE ALIAS: APC_HIPPS

                                      CODES:
                                        REFER TO: REV_CNTR_APC_TB
                                                  IN THE CODES APPENDIX

                                      SOURCE:
                                      CWF

  9. Revenue Center HCFA Common    CHAR    5    39   43   HCFA's Common Procedure Coding System (HCPCS)
     Procedure Coding System                              is a collection of codes that represent procedures,
     Code                                                 supplies, products and services which may be
                                                          provided to Medicare beneficiaries and to
                                                          individuals enrolled in private health
                                                          insurance programs.  The codes are divided
                                                          into three levels, or groups, as described
                                                          below:

                                      DB2 ALIAS: REV_CNTR_HCPCS_CD
                                      SAS ALIAS: HCPCS_CD
                                      STANDARD ALIAS: REV_CNTR_HCPCS_CD
                                      SYSTEM ALIAS: LTHIPPS
                                      TITLE ALIAS: HCPCS_CD

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                                            POSITIONS
              NAME              TYPE  LENGTH BEG  END                              CONTENTS
     -------------------------  ----  ------ --------- ------------------------------------------------------------

                                      CODES:
                                        REFER TO: CLM_HIPPS_TB
                                                  IN THE CODES APPENDIX
```

COMMENT:
Prior to Version H this field was named:
HCPCS_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS)
or '0023' (HH PPS), this field contains the Health
Insurance PPS (HIPPS) code. The HIPPS code for
SNF PPS contains the rate code/assessment type that
identifies (1) RUG-III group the beneficiary was
classified into as of the RAI MDS assessment reference
date and (2) the type of assessment for payment pur-
poses.

The HIPPS code for Home Health PPS identifies
(1) the three case-mix dimensions of the HHRG system,
clinical, functional and utilization, from which a
beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented by the HIPPS coding, will be
the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB.

Level I
    Codes and descriptors copyrighted by the American
    Medical Association's Current Procedural
    Terminology, Fourth Edition (CPT-4). These are
    5 position numeric codes representing physician
    and nonphysician services.

    **** Note: ****
    CPT-4 codes including both long and short
    descriptions shall be used in accordance with the
    HCFA/AMA agreement. Any other use violates the
    AMA copyright.

Level II
    Includes codes and descriptors copyrighted by
    the American Dental Association's Current Dental
    Terminology, Second Edition (CDT-2). These are
    5 position alpha-numeric codes comprising
    the D series. All other level II codes and
    descriptors are approved and maintained jointly
    by the alpha-numeric editorial panel (consisting
    of HCFA, the Health Insurance Association of

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                                    POSITIONS
                           TYPE  LENGTH BEG  END
        NAME                                                          CONTENTS
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                                           America, and the Blue Cross and Blue Shield
                                           Association). These are 5 position alpha-
                                           numeric codes representing primarily items and

```
                                    nonphysician services that are not
                                    represented in the level I codes.

                                    Level III
                                      Codes and descriptors developed by Medicare
                                      carriers for use at the local (carrier) level.
                                      These are 5 position alpha-numeric codes in the
                                      W, X, Y or Z series representing physician
                                      and nonphysician services that are not
                                      represented in the level I or level II codes.

    10. Revenue Center HCPCS        CHAR    2   44   45   A first modifier to the procedure code to enable a more
        Initial Modifier Code                               specific procedure identification for the claim.

                                                          DB2 ALIAS: REV_HCPCS_MDFR_CD
                                                          SAS ALIAS: MDFR_CD1
                                                          STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD
                                                          TITLE ALIAS: INITIAL_MODIFIER

                                                          EDIT-RULES:
                                                          Carrier Information File

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          HCPCS_INITL_MDFR_CD.  With Version H, a prefix
                                                          was added to denote the location of this field
                                                          on each claim type (institutional: REV_CNTR and
                                                          non-institutional: LINE).

                                                          SOURCE:
                                                          CWF

    11. Revenue Center HCPCS Second CHAR    2   46   47   A second modifier to the procedure code to make it more
        Modifier Code                                       specific than the first modifier code to identify the
                                                            procedures performed on the beneficiary for the claim.

                                                          DB2 ALIAS: REV_HCPCS_2ND_CD
                                                          SAS ALIAS: MDFR_CD2
                                                          STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
                                                          TITLE ALIAS: SECOND_MODIFIER

                                                          EDIT-RULES:
                                                          CARRIER INFORMATION FILE

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          HCPCS_2ND_MDFR_CD.  With Version H, a prefix
                                                          was added to denote the location of this field
                                                          on each claim type (institutional: REV_CNTR and
                                                          non-institutional: LINE).
```

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                                        POSITIONS
                NAME              TYPE  LENGTH BEG  END                           CONTENTS
    ------------------------- ---- ------ --------  ------------------------------------------------------------

                                                          SOURCE:
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CWF

12. Revenue Center HCPCS Third   CHAR   2   48   49   Effective with Version I, a third modifier to the
    Modifier Code   procedure code to make it more specific than the
                                                          second modifier code to identify the procedures
                                                          performed on the beneficiary for the claim.

                                                          DB2 ALIAS: REV_HCPCS_3RD_CD
                                                          SAS ALIAS: MDFR_CD3
                                                          STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
                                                          TITLE ALIAS: THIRD_MODIFIER

                                                          EDIT-RULES:
                                                          CARRIER INFORMATION FILE

                                                          COMMENT:
                                                          NOTE: Beginning with NCH weekly process date
                                                          8/18/00, this field will be populated with data.
                                                          Claims processed prior to 8/18/00 will contain
                                                          spaces in this field.

                                                          SOURCE:
                                                          CWF

13. Revenue Center HCPCS Fourth   CHAR   2   50   51   Effective with Version I, a fourth modifier to the
    Modifier Code   procedure code to make it more specific than the
                                                          third modifier code to identify the procedures
                                                          performed on the beneficiary for the claim.

                                                          DB2 ALIAS: REV_HCPCS_4TH_CD
                                                          SAS ALIAS: MDFR_CD4
                                                          STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
                                                          TITLE ALIAS: FOURTH_MODIFIER

                                                          EDIT-RULES:
                                                          CARRIER INFORMATION FILE

                                                          COMMENT:
                                                          NOTE: Beginning with NCH weekly process date
                                                          8/18/00, this field will be populated with data.
                                                          Claims processed prior to 8/18/00 will contain
                                                          spaces in this field.

                                                          SOURCE:
                                                          CWF

14. Revenue Center HCPCS Fifth   CHAR   2   52   53   Effective with Version I, a fifth modifier to the
    Modifier Code   procedure code to make it more specific than the
                                                          fourth modifier code to identify the procedures
                                                          performed on the beneficiary for the claim.

                                  POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ------------------------- ---- ------ -------- ---

                                                          DB2 ALIAS: REV_HCPCS_5TH_CD

```
                                      SAS ALIAS: MDFR_CD5
                                      STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
                                      TITLE ALIAS: FIFTH_MODIFIER

                                      EDIT-RULES:
                                      CARRIER INFORMATION FILE

                                      COMMENT:
                                      NOTE:  Beginning with NCH weekly process date
                                      8/18/00, this field will be populated with data.
                                      Claims processed prior to 8/18/00 will contain
                                      spaces in this field.

                                      SOURCE:
                                      CWF

  15. Revenue Center Payment      CHAR    2   54   55   Effective with Version 'I', the code used to
      Method Indicator Code                              identify how the service is priced for payment.
                                                         This field is made up of two pieces of data,
                                                         1st position being the service indicator and
                                                         the 2nd position being the payment indicator.

                                      NOTE:  Beginning with NCH weekly process date
                                      8/18/00, this field will be populated with data.
                                      Claims processed prior to 8/18/00 will contain
                                      spaces in this field.

                                      DB2 ALIAS: REV_PMT_MTHD_CD
                                      SAS ALIAS: PMTMTHD
                                      STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
                                      SYSTEM ALIAS: LTPMTHD
                                      TITLE ALIAS: PMT_MTHD

                                      CODES:
                                        REFER TO: REV_CNTR_PMT_MTHD_IND_TB
                                                  IN THE CODES APPENDIX

                                      SOURCE:
                                      CWF

  16. Revenue Center Discount     CHAR    1   56   56   Effective with Version 'I', for all services
      Indicator Code                                     subject to Outpatient PPS, this code represents
                                                         a factor that specifies the amount of any APC
                                                         discount.  The discounting factor is applied
                                                         to a line item with a service indicator (part
                                                         of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'.  The
                                                         flag is applicable when more than one significant
                                                         procedure is performed. **If there is no dis-
                                                         counting the factor will be 1.0.**
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                                    POSITIONS
            NAME              TYPE  LENGTH BEG  END                          CONTENTS
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                                      NOTE1:  Beginning with NCH weekly process date
                                      8/18/00, this field will be populated with data.
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                                      Claims processed prior to 8/18/00 will contain
                                      spaces in this field.

                                      DB2 ALIAS: REV_DSCNT_IND_CD
                                      SAS ALIAS: DSCNTIND
                                      STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
                                      SYSTEM ALIAS: LTDSCNT
                                      TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

                                      CODES:
                                      *DISCOUNTING FORMULAS*
                                      1 = 1.0
                                      2 = (1.0+D(U-1))/U
                                      3 = T/U
                                      4 = (1+D)/U
                                      5 = D
                                      6 = TD/U
                                      7 = D(1+D)/U
                                      8 = 2.0/U

                                      SOURCE:
                                      CWF

    17. Revenue Center Packaging    CHAR    1   57  57  Effective with Version 'I', for all services
        Indicator Code                                  subject to Outpatient PPS, the code used to
                                                        identify those services that are packaged/
                                                        bundled with another service.

                                      NOTE:  Beginning with NCH weekly process date
                                      8/18/00, this field will be populated with data.
                                      Claims processed prior to 8/18/00 will contain
                                      spaces in this field.

                                      DB2 ALIAS: REV_PACKG_IND_CD
                                      SAS ALIAS: PACKGIND
                                      STANDARD ALIAS: REV_CNTR_PACKG_IND_CD
                                      SYSTEM ALIAS: LTPACKG
                                      TITLE ALIAS: REV_CNTR_PACKG_IND

                                      CODES:
                                      0 = Not packaged
                                      1 = Packaged service (service indicator N)
                                      2 = Packaged as part of partial hospitalization
                                          per diem or daily mental health service
                                          per diem

                                      SOURCE:
                                      CWF

    18. Revenue Center Pricing      CHAR    2   58  59  Effective with Version 'I', the code used
        Indicator Code                                  to identify if there was a deviation from
                                                        the standard method of calculating payment
                                                        amount.
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                                         POSITIONS
                 NAME               TYPE  LENGTH BEG  END                        CONTENTS
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                                                   NOTE:  Beginning with NCH weekly process date
                                                   8/18/00, this field will be populated with data.
                                                   Claims processed prior to 8/18/00 will contain
                                                   spaces in this field.

                                                   DB2 ALIAS: REV_PRICNG_IND_CD
                                                   SAS ALIAS: PRICNG
                                                   STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD
                                                   SYSTEM ALIAS: LTPRICNG
                                                   TITLE ALIAS: REV_CNTR_PRICNG_IND

                                                   CODES:
                                                     REFER TO: REV_CNTR_PRICNG_IND_TB
                                                               IN THE CODES APPENDIX

                                                   SOURCE:
                                                   CWF

     19. Revenue Center Obligation    CHAR    1    60   60   Effective with Version 'I' the code used
         to Accept As Full (OTAF)                            to indicate that the provider was obligated
         Payment Code                                        to accept as full payment the amount re-
                                                             ceived from the primary (or secondary) payer.

                                                   NOTE:  Beginning with NCH weekly process date
                                                   7/7/00, this field will be populated with data.
                                                   Claims processed prior to 7/7/00 will contain
                                                   spaces in this field.

                                                   DB2 ALIAS: REV_OTAF1_IND_CD
                                                   SAS ALIAS: OTAF_1
                                                   STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD
                                                   TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD

                                                   EDIT-RULES:
                                                   Y = provider is obligated to accept the payment
                                                       as payment in full for the service.
                                                   N or blank  = provider is not obligated to accept
                                                       the payment, or there is no payment by a prior
                                                       payer.

                                                   SOURCE:
                                                   CWF

     20. Revenue Center IDE, NDC,     CHAR   24    61   84   Effective with Version H, the exemption number
         UPC Number                                         assigned by the Food and Drug Administration (FDA)
                                                            to an investigational device after a manufacturer
                                                            has been approved by FDA to conduct a clinical
                                                            trial on that device.   HCFA established a new
                                                            policy of covering certain IDE's which was
                                                            implemented in claims processing on 10/1/96
                                                            (which is NCH weekly process 10/4/96) for service
                                                            dates beginning 10/1/95.  IDE's are always
                                                            associated with revenue center code '0624'.
```

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                           POSITIONS
            NAME          TYPE  LENGTH BEG  END                      CONTENTS
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                                               NOTE1:  Prior to Version H a 'dummy' revenue
                                               center code '0624' trailer was created to store
                                               IDE's.   The IDE number was housed in two fields:
                                               HCPCS code and HCPCS initial modifier; the second
                                               modifier contained the value 'ID'.  There can be
                                               up to 7 distinct IDE numbers associated with an
                                               '0624' dummy trailer.  During the Version H con-
                                               version IDE's were moved from the dummy '0624'
                                               trailer to this dedicated field.

                                               NOTE2:  Effective with Version 'I', this field was
                                               renamed to eventually accommodate the National Drug Code
                                               (NDC) and the Universal Product Code (UPC).  This field
                                               could contain either of these 3 fields (there would never
                                               be an instance where more than one would come in on
                                               a claim).  The size of this field was expanded to X(24)
                                               to accommodate either of the new fields (under Version
                                               'H' it was X(7).  DATA ANAMOLY/LIMITATION:  During an
                                               CWFMQA review an edit revealed the IDE was missing.
                                               The problem occurs in claim with an NCH weekly pro-
                                               cess dates of 6/9/00 through 9/8/00.  During processing
                                               of the new format the program receives the IDE but
                                               then blanked out the data.

                                               DB2 ALIAS: IDE_NDC_UPC_NUM
                                               SAS ALIAS: IDENDC
                                               STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
                                               TITLE ALIAS: IDE_NDC_UPC

                                               SOURCE:
                                               CWF

  21. Revenue Center Unit Count   CHAR     8   85   92   A quantitative measure (unit) of the number of times the
                                               service or procedure being reported was performed according
                                               to the revenue center/HCPCS code definition as described on
                                               an institutional claim.

                                               Depending on type of service, units are measured by number
                                               of covered days in a particular accommodation, pints of
                                               blood, emergency room visits, clinic visits, dialysis
                                               treatments (sessions or days), outpatient therapy visits,
                                               and outpatient clinical diagnostic laboratory tests.

                                               NOTE1:  When revenue center code = '0022' (SNF PPS) the unit
                                               count will reflect the number of covered days for each HIPPS
                                               code and, if applicable, the number of visits for each rehab
                                               therapy code.

                                               7 DIGITS SIGNED

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                           POSITIONS
            NAME          TYPE  LENGTH BEG  END                      CONTENTS
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    -------------------------   ----  ------  -------  -------------------------------------------------------------
                                                        DB2 ALIAS: REV_CNTR_UNIT_CNT
                                                        SAS ALIAS: REV_UNIT
                                                        STANDARD ALIAS: REV_CNTR_UNIT_CNT
                                                        TITLE ALIAS: UNITS

                                                        EDIT-RULES:
                                                        +9(7)

                                                        SOURCE:
                                                        CWF

22. Revenue Center Rate Amount    CHAR    13    93  105  Charges relating to unit cost associated with
                                                        the revenue center code.  Exception (encounter
                                                        data only):  If plan (e.g. MCO) does not know
                                                        the actual rate for the accommodations, $1 will
                                                        be reported in the field.

                                                        NOTE1:  For SNF PPS claims (when revenue center
                                                        code equals '0022'), HCFA has developed a SNF
                                                        PRICER to compute the rate based on the provider
                                                        supplied coding for the MDS RUGS III group and
                                                        assessment type (HIPPS code, stored in revenue
                                                        center HCPCS code field).

                                                        NOTE2:  For OP PPS claims, HCFA has developed a
                                                        PRICER to compute the rate based on the Ambulatory
                                                        Payment Classification (APC), discount factor,
                                                        units of service and the wage index.

                                                        NOTE3:  Under HH PPS (when revenue center
                                                        code equals '0023'), HCFA has developed a HHA
                                                        PRICER to compute the rate.  On the RAP, the rate is
                                                        determined using the case mix weight associated with
                                                        the HIPPS code, adjusting it for the wage index
                                                        for the beneficiary's site of service, then
                                                        multiplying the result by 60% or 50%, depending on
                                                        whether or not the RAP is for a first episode.

                                                        On the final claim, the HIPPS code could change the
                                                        payment if the therapy threshold is not met, or
                                                        partial episode payment (PEP) adjustment or a
                                                        significant change in condition (SCIC) adjustment.
                                                        In cases of SCICs, there will be more than one
                                                        '0023' revenue center line, each representing the
                                                        payment made at each case-mix level.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: REV_CNTR_RATE_AMT
                                                        SAS ALIAS: REV_RATE
                                                        STANDARD ALIAS: REV_CNTR_RATE_AMT
                                                        TITLE ALIAS: CHARGE_PER_UNIT

                                                        EDIT-RULES:
                                                        +9(9).99
```

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                                   POSITIONS
            NAME              TYPE  LENGTH BEG  END                     CONTENTS
    ------------------------  ----  ------ --------  -------------------------------------------------------------

                                                    EFFECTIVE-DATE: 10/01/1993

                                                    COMMENT:
                                                    Prior to Version H the size of this field was:
                                                    S9(7)V99.

                                                    SOURCE:
                                                    CWF

    23. Revenue Center Blood  CHAR    13   106  118  Effective with Version 'I', the amount of money
        Deductible Amount                            for which the intermediary determined the
                                                     beneficiary is liable for the blood deductible
                                                     for the line item service.

                                                     NOTE:  Beginning with NCH weekly process date
                                                     7/7/00, this field will be populated with data.
                                                     Claims processed prior to 7/7/00 will contain
                                                     spaces in this field.

                                                     9.2 DIGITS SIGNED

                                                     DB2 ALIAS: REV_BLOOD_DDCTBL
                                                     SAS ALIAS: REVBLOOD
                                                     STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT
                                                     TITLE ALIAS: BLOOD_DDCTBL_AMT

                                                     EDIT-RULES:
                                                     +9(9).99

                                                     SOURCE:
                                                     CWF

    24. Revenue Center Cash   CHAR    13   119  131  Effective with Version 'I' the amount of cash
        Deductible Amount                            deductible the beneficiary paid for the line
                                                     item service.

                                                     NOTE:  Beginning with NCH weekly process date
                                                     7/7/00, this field will be populated with data.
                                                     Claims processed prior to 7/7/00 will contain
                                                     spaces in this field.

                                                     9.2 DIGITS SIGNED

                                                     DB2 ALIAS: REV_CASH_DDCTBL
                                                     SAS ALIAS: REVDCTBL
                                                     STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT
                                                     TITLE ALIAS: CASH_DDCTBL

                                                     EDIT-RULES:
                                                     +9(9).99
```

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                                POSITIONS
         NAME              TYPE  LENGTH BEG  END                       CONTENTS
------------------------   ----  ------ --------   ------------------------------------------------------------
                                                   SOURCE:
                                                   CWF

25. Revenue Center           CHAR    13   132  144 Effective with Version 'I', the amount of
    Coinsurance/Wage Adjusted                      coinsurance applicable to the line item
    Coinsurance Amount                             service defined by the revenue center and
                                                   HCPCS codes.  For those services subject to
                                                   Outpatient PPS, the applicable coinsurance
                                                   is wage adjusted.

                                                   NOTE1:  This field will have either a zero
                                                   (for services for which coinsurance is not
                                                   applicable), a regular coinsurance amount
                                                   (calculated on either charges or a fee
                                                   schedule) or if subject to OP PPS the national
                                                   coinsurance amount will be wage adjusted.
                                                   The wage adjusted coinsurance is based on the
                                                   MSA where the provider is located or assigned
                                                   as a result of a reclassification.

                                                   NOTE2:  Beginning with NCH weekly process date
                                                   8/18/00, this field will be populated with data.
                                                   Claims processed prior to 8/18/00 will contain
                                                   spaces in this field.

                                                   9.2 DIGITS SIGNED

                                                   DB2 ALIAS: ADJSTD_COINSRNC
                                                   SAS ALIAS: WAGEADJ
                                                   STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT
                                                   TITLE ALIAS: WAGE_ADJSTD_COINS

                                                   EDIT-RULES:
                                                   +9(9).99

                                                   SOURCE:
                                                   CWF

26. Revenue Center Reduced   CHAR    13   145  157 Effective with Version 'I', for all services
    Coinsurance Amount                             subject to Outpatient PPS, the amount of
                                                   coinsurance applicable to the line for a
                                                   particular service (HCPCS) for which the
                                                   provider has elected to reduce the coinsurance
                                                   amount.

                                                   NOTE1:  The reduced coinsurance amount cannot
                                                   be lower than 20% of the payment rate for the
                                                   APC line.

                                                   NOTE2:  Beginning with NCH weekly process date
                                                   8/18/00, this field will be populated with data.
                                                   Claims processed prior to 8/18/00 will contain
                                                   spaces in this field.
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                                          POSITIONS
              NAME             TYPE  LENGTH BEG  END                      CONTENTS
    -------------------------  ----  ------ ---------  -------------------------------------------------------
                                                       DB2 ALIAS: RDCD_COINSRNC
                                                       SAS ALIAS: RDCDCOIN
                                                       STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
                                                       TITLE ALIAS: REDUCED_COINS

                                                       EDIT-RULES:
                                                       +9(9).99

                                                       SOURCE:
                                                       CWF

    27. Revenue Center 1st Medicare  CHAR    13   158  170  Effective with Version 'I', the amount paid by
        Secondary Payer Paid                               the primary payer when the payer is primary to
        Amount                                             Medicare (Medicare is secondary or tertiary).

                                                       NOTE:  Beginning with NCH weekly process date
                                                       7/7/00, this field will be populated with data.
                                                       Claims processed prior to 7/7/00 will contain
                                                       spaces in this field.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: REV_MSP1_PD_AMT
                                                       SAS ALIAS: REV_MSP1
                                                       STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
                                                       TITLE ALIAS: MSP PAID AMOUNT

                                                       EDIT-RULES:
                                                       +9(9).99

                                                       SOURCE:
                                                       CWF

    28. Revenue Center 2nd Medicare  CHAR    13   171  183  Effective with Version 'I', the amount paid by
        Secondary Payer Paid                               the secondary payer when two payers are primary
        Amount                                             to Medicare (Medicare is the tertiary payer).

                                                       NOTE:  Beginning with NCH weekly process date
                                                       7/7/00, this field will be populated with data.
                                                       Claims processed prior to 7/7/00 will contain
                                                       spaces in this field.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: REV_MSP2_PD_AMT
                                                       SAS ALIAS: REV_MSP2
                                                       STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
                                                       TITLE ALIAS: MSP PAID AMOUNT

                                                       EDIT-RULES:
```

```
                              +9(9).99

                              SOURCE:
                              CWF

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                                POSITIONS
              NAME          TYPE  LENGTH BEG  END                     CONTENTS
   ------------------------- ----  ------ --------  ----------------------------------------------------------

   29. Revenue Center Provider   CHAR   13   184  196   Effective with Version 'I', the amount paid
       Payment Amount                                   to the provider for the services reported
                                                        on the line item.

                                                        NOTE:  Beginning with NCH weekly process date
                                                        7/7/00, this field will be populated with data.
                                                        Claims processed prior to 7/7/00 will contain
                                                        spaces in this field.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: REV_PRVDR_PMT_AMT
                                                        SAS ALIAS: RPRVDPMT
                                                        STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
                                                        TITLE ALIAS: REV_PRVDR_PMT

                                                        EDIT-RULES:
                                                        +9(9).99

                                                        SOURCE:
                                                        CWF

   30. Revenue Center Beneficiary  CHAR  13   197  209   Effective with Version I, the amount paid
       Payment Amount                                    to the beneficiary for the services reported
                                                         on the line item.

                                                         NOTE:  Beginning with NCH weekly process date
                                                         7/7/00, this field will be populated with data.
                                                         Claims processed prior to 7/7/00 will contain
                                                         spaces in this field.

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: REV_BENE_PMT_AMT
                                                         SAS ALIAS: RBENEPMT
                                                         STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
                                                         TITLE ALIAS: REV_BENE_PMT

                                                         EDIT-RULES:
                                                         +9(9).99

                                                         SOURCE:
                                                         CWF

   31. Revenue Center Patient    CHAR   13   210  222   Effective with Version I, the amount paid
       Responsibility Payment                           by the beneficiary to the provider for the
       Amount                                           line item service.
```

NOTE: Beginning with NCH weekly process date
7/7/00 this field was populated with data.
Claims processed prior to 7/7/00 will contain
zeroes in this field.

9.2 DIGITS SIGNED

```
                                       POSITIONS
                  NAME           TYPE  LENGTH BEG  END                         CONTENTS
         -------------------------  ----  ------ ---------  ------------------------------------------------------------
```


DB2 ALIAS: REV_PTNT_RESP_AMT
SAS ALIAS: PTNTRESP
STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS: REV_PTNT_RESP

EDIT-RULES:
+9(9).99

SOURCE:
CWF

32. Revenue Center Payment   CHAR   13   223 235   Effective with Version 'I', the line item
    Amount   Medicare payment amount for the specific
                                                      revenue center.

                                                      Under OP PPS, PRICER will compute the
                                                      standard OPPS payment for a line item based
                                                      on the payment APC.

                                                      Under HH PPS, PRICER will compute/return
                                                      a line item payment amount for the case-mixed,
                                                      wage-index adjusted HIPPS code assigned to
                                                      the '0023' revenue center line. The HIPPS
                                                      code will be stored in the Revenue Center
                                                      HCPCS code field.

                                                      9.2 DIGITS SIGNED

                                                      COMMON ALIAS: REIMBURSEMENT
                                                      DB2 ALIAS: REV_CNTR_PMT_AMT
                                                      SAS ALIAS: REVPMT
                                                      STANDARD ALIAS: REV_CNTR_PMT_AMT
                                                      TITLE ALIAS: REIMBURSEMENT

                                                      EDIT-RULES:
                                                      +9(9).99

                                                      SOURCE:
                                                      CWF

33. Revenue Center Total Charge CHAR   13   236 248   The total charges (covered and non-covered) for all
    Amount   accommodations and services (related to the revenue code)
                                                        for a billing period before reduction for the deductible and
                                                        coinsurance amounts and before an adjustment for the cost of

services provided. NOTE: For accommodation revenue center
total charges must equal the rate times units (days).

EXCEPTIONS:
(1) For SNF RUGS demo claims only (9000 series revenue
center codes), this field contains SNF customary
accommodation charge, (ie., charges related to the
accommodation revenue center code that would have been
applicable if the provider had not been participating in the
demo).

| | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

(2) For SNF PPS (non demo claims), when revenue center code
= '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code =
'0023', the total charges will equal the dollar amount for
the '0023' line.

(4) For Home Health PPS (final claim), when revenue center
code = '0023', the total charges will be the sum of the
revenue center code lines (other than '0023').

(5) For encounter data, if the plan (e.g. MCO) does not
know the actual charges for the accommodations the total
charges will be $1 (rate) times units (days).

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT
SAS ALIAS: REV_CHRG
STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

34. Revenue Center Non-Covered   CHAR   13   249 261   The charge amount related to a revenue center code for
    Charge Amount   services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and
the element was only present on the Inpatient/SNF format.
As of NCH weekly process date 10/3/97 this field was added
to all institutional claim types.

9.2 DIGITS SIGNED

```
                                        DB2 ALIAS: REV_NCVR_CHRG_AMT
                                        SAS ALIAS: REV_NCVR
                                        STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
                                        TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES

                                        EDIT-RULES:
                                        +9(9).99

                                        SOURCE:
                                        CWF
```

1   FI Home Health Agency Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                  POSITIONS
                NAME          TYPE  LENGTH BEG  END                       CONTENTS
        ------------------------  ----  ------ ---------  -------------------------------------------------------------

    35. Revenue Center Deductible  CHAR    1   262  262   Code indicating whether the revenue center charges
        Coinsurance Code                                  are subject to deductible and/or coinsurance.

                                        DB2 ALIAS: DDCTBL_COINSRNC_CD
                                        SAS ALIAS: REVDEDCD
                                        STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD
                                        TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

                                        CODES:
                                          REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
                                                    IN THE CODES APPENDIX

                                        SOURCE:
                                        CWF
```

```
1    BENE_IDENT_TB                    Beneficiary Identification Code (BIC) Table
     -------------                    -------------------------------------------

                          Social Security Administration:

                          A  = Primary claimant
                          B  = Aged wife, age 62 or over (1st
                               claimant)
                          B1 = Aged husband, age 62 or over (1st
                               claimant)
                          B2 = Young wife, with a child in her care
                               (1st claimant)
                          B3 = Aged wife (2nd claimant)
                          B4 = Aged husband (2nd claimant)
                          B5 = Young wife (2nd claimant)
                          B6 = Divorced wife, age 62 or over (1st
                               claimant)
                          B7 = Young wife (3rd claimant)
                          B8 = Aged wife (3rd claimant)
                          B9 = Divorced wife (2nd claimant)
                          BA = Aged wife (4th claimant)
                          BD = Aged wife (5th claimant)
                          BG = Aged husband (3rd claimant)
                          BH = Aged husband (4th claimant)
                          BJ = Aged husband (5th claimant)
```

```
                          BK = Young wife (4th claimant)
                          BL = Young wife (5th claimant)
                          BN = Divorced wife (3rd claimant)
                          BP = Divorced wife (4th claimant)
                          BQ = Divorced wife (5th claimant)
                          BR = Divorced husband (1st claimant)
                          BT = Divorced husband (2nd claimant)
                          BW = Young husband (2nd claimant)
                          BY = Young husband (1st claimant)
                          C1-C9,CA-CZ = Child (includes minor, student
                                        or disabled child)
                          D  = Aged widow, 60 or over (1st claimant)
                          D1 = Aged widower, age 60 or over (1st
                               claimant)
                          D2 = Aged widow (2nd claimant)
                          D3 = Aged widower (2nd claimant)
                          D4 = Widow (remarried after attainment of
                               age 60) (1st claimant)
                          D5 = Widower (remarried after attainment of
                               age 60) (1st claimant)
                          D6 = Surviving divorced wife, age 60 or over
                               (1st claimant)
                          D7 = Surviving divorced wife (2nd claimant)
                          D8 = Aged widow (3rd claimant)
                          D9 = Remarried widow (2nd claimant)
                          DA = Remarried widow (3rd claimant)
                          DC = Surviving divorced husband (1st claimant)
                          DD = Aged widow (4th claimant)
                          DG = Aged widow (5th claimant)
                          DH = Aged widower (3rd claimant)
                          DJ = Aged widower (4th claimant)
                          DK = Aged widower (5th claimant)
                          DL = Remarried widow (4th claimant)
                          DM = Surviving divorced husband (2nd
                               claimant)
                          DN = Remarried widow (5th claimant)
```

1	BENE_IDENT_TB	Beneficiary Identification Code (BIC) Table
	-------------	---

```
                          DP = Remarried widower (2nd claimant)
                          DQ = Remarried widower (3rd claimant)
                          DR = Remarried widower (4th claimant)
                          DS = Surviving divorced husband (3rd
                               claimant)
                          DT = Remarried widower (5th claimant)
                          DV = Surviving divorced wife (3rd claimant)
                          DW = Surviving divorced wife (4th claimant)
                          DX = Surviving divorced husband (4th
                               claimant)
                          DY = Surviving divorced wife (5th claimant)
                          DZ = Surviving divorced husband (5th
                               claimant)
                          E  = Mother (widow) (1st claimant)
                          E1 = Surviving divorced mother (1st
                               claimant)
                          E2 = Mother (widow) (2nd claimant)
                          E3 = Surviving divorced mother (2nd
                               claimant)
```

```
                                        E4 = Father (widower) (1st claimant)
                                        E5 = Surviving divorced father (widower)
                                             (1st claimant)
                                        E6 = Father (widower) (2nd claimant)
                                        E7 = Mother (widow) (3rd claimant)
                                        E8 = Mother (widow) (4th claimant)
                                        E9 = Surviving divorced father (widower)
                                             (2nd claimant)
                                        EA = Mother (widow) (5th claimant)
                                        EB = Surviving divorced mother (3rd
                                             claimant)
                                        EC = Surviving divorced mother (4th
                                             claimant)
                                        ED = Surviving divorced mother (5th
                                             claimant
                                        EF = Father (widower) (3rd claimant)
                                        EG = Father (widower) (4th claimant)
                                        EH = Father (widower) (5th claimant)
                                        EJ = Surviving divorced father (3rd
                                             claimant)
                                        EK = Surviving divorced father (4th
                                             claimant)
                                        EM = Surviving divorced father (5th
                                             claimant)
                                        F1 = Father
                                        F2 = Mother
                                        F3 = Stepfather
                                        F4 = Stepmother
                                        F5 = Adopting father
                                        F6 = Adopting mother
                                        F7 = Second alleged father
                                        F8 = Second alleged mother
                                        J1 = Primary prouty entitled to HIB
                                             (less than 3 Q.C.) (general fund)
                                        J2 = Primary prouty entitled to HIB
                                             (over 2 Q.C.) (RSI trust fund)
                                        J3 = Primary prouty not entitled to HIB
                                             (less than 3 Q.C.) (general fund)
                                        J4 = Primary prouty not entitled to HIB
1         BENE_IDENT_TB                     Beneficiary Identification Code (BIC) Table
          -------------                     ------------------------------------------

                                             (over 2 Q.C.) (RSI trust fund)
                                        K1 = Prouty wife entitled to HIB (less than
                                             3 Q.C.) (general fund) (1st claimant)
                                        K2 = Prouty wife entitled to HIB (over 2
                                             Q.C.) (RSI trust fund) (1st claimant)
                                        K3 = Prouty wife not entitled to HIB (less
                                             than 3 Q.C.) (general fund) (1st
                                             claimant)
                                        K4 = Prouty wife not entitled to HIB (over
                                             2 Q.C.) (RSI trust fund) (1st
                                             claimant)
                                        K5 = Prouty wife entitled to HIB (less than
                                             3 Q.C.) (general fund) (2nd claimant)
                                        K6 = Prouty wife entitled to HIB (over 2
                                             Q.C.) (RSI trust fund) (2nd claimant)
                                        K7 = Prouty wife not entitled to HIB (less
```

```
                        than 3 Q.C.) (general fund) (2nd
                        claimant)
           K8 = Prouty wife not entitled to HIB (over
                2 Q.C.) (RSI trust fund) (2nd
                claimant)
           K9 = Prouty wife entitled to HIB (less than
                3 Q.C.) (general fund) (3rd claimant)
           KA = Prouty wife entitled to HIB (over 2
                Q.C.) (RSI trust fund) (3rd claimant)
           KB = Prouty wife not entitled to HIB (less
                than 3 Q.C.) (general fund) (3rd
                claimant)
           KC = Prouty wife not entitled to HIB (over
                2 Q.C.) (RSI trust fund) (3rd
                claimant)
           KD = Prouty wife entitled to HIB (less than
                3 Q.C.) (general fund) (4th claimant)
           KE = Prouty wife entitled to HIB (over 2 Q.C
                (4th claimant)
           KF = Prouty wife not entitled to HIB (less
                than 3 Q.C.)(4th claimant)
           KG = Prouty wife not entitled to HIB (over
                2 Q.C.)(4th claimant)
           KH = Prouty wife entitled to HIB (less than
                3 Q.C.)(5th claimant)
           KJ = Prouty wife entitled to HIB (over 2
                Q.C.) (5th claimant)
           KL = Prouty wife not entitled to HIB (less
                than 3 Q.C.)(5th claimant)
           KM = Prouty wife not entitled to HIB (over
                2 Q.C.) (5th claimant)
           M  = Uninsured-not qualified for deemed HIB
           M1 = Uninsured-qualified but refused HIB
           T  = Uninsured-entitled to HIB under deemed
                or renal provisions
           TA = MQGE (primary claimant)
           TB = MQGE aged spouse (first claimant)
           TC = MQGE disabled adult child (first claimant)
           TD = MQGE aged widow(er) (first claimant)
           TE = MQGE young widow(er) (first claimant)
           TF = MQGE parent (male)
           TG = MQGE aged spouse (second claimant)
1      BENE_IDENT_TB              Beneficiary Identification Code (BIC) Table
       -------------              -------------------------------------------

           TH = MQGE aged spouse (third claimant)
           TJ = MQGE aged spouse (fourth claimant)
           TK = MQGE aged spouse (fifth claimant)
           TL = MQGE aged widow(er) (second claimant)
           TM = MQGE aged widow(er) (third claimant)
           TN = MQGE aged widow(er) (fourth claimant)
           TP = MQGE aged widow(er) (fifth claimant)
           TQ = MQGE parent (female)
           TR = MQGE young widow(er) (second claimant)
           TS = MQGE young widow(er) (third claimant)
           TT = MQGE young widow(er) (fourth claimant)
           TU = MQGE young widow(er) (fifth claimant)
           TV = MQGE disabled widow(er) fifth claimant
```

```
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth
        claimant)
W  = Disabled widow, age 50 or over (1st
     claimant)
W1 = Disabled widower, age 50 or over (1st
     claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st
     claimant)
W7 = Disabled surviving divorced wife (2nd
     claimant)
W8 = Disabled surviving divorced wife (3rd
     claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th
     claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th
     claimant)
WR = Disabled surviving divorced husband
     (1st claimant)
WT = Disabled surviving divorced husband
     (2nd claimant)

Railroad Retirement Board:

   NOTE:
   Employee:  a Medicare beneficiary who is
              still working or a worker who
              died before retirement
   Annuitant: a person who retired under the
              railroad retirement act on or
              after 03/01/37
   Pensioner: a person who retired prior to
              03/01/37 and was included in the
              railroad retirement act
```

1	BENE_IDENT_TB	Beneficiary Identification Code (BIC) Table
	-------------	---

```
10 = Retirement - employee or annuitant
80 = RR pensioner (age or disability)
14 = Spouse of RR employee or annuitant
     (husband or wife)
84 = Spouse of RR pensioner
43 = Child of RR employee
13 = Child of RR annuitant
17 = Disabled adult child of RR annuitant
46 = Widow/widower of RR employee
```

```
     16 = Widow/widower of RR annuitant
     86 = Widow/widower of RR pensioner
     43 = Widow of employee with a child in her care
     13 = Widow of annuitant with a child in her care
     83 = Widow of pensioner with a child in her care
     45 = Parent of employee
     15 = Parent of annuitant
     85 = Parent of pensioner
     11 = Survivor joint annuitant
          (reduced benefits taken to insure benefits
           for surviving spouse)


1    BENE_PRMRY_PYR_TB                    Beneficiary Primary Payer Table
     -----------------                    ------------------------------


     A = Working aged bene/spouse with employer
         group health plan (EGHP)
     B = End stage renal disease (ESRD) beneficiary
         in the 18 month coordination period with
         an employer group health plan
     C = Conditional payment by Medicare; future
         reimbursement expected
     D = Automobile no-fault (eff. 4/97; Prior
         to 3/94, also included any liability
         insurance)
     E = Workers' compensation
     F = Public Health Service or other federal
         agency (other than Dept. of Veterans
         Affairs)
     G = Working disabled bene (under age 65
         with LGHP)
     H = Black Lung
     I = Dept. of Veterans Affairs
     J = Any liability insurance
         (eff. 3/94 - 3/97)
     L = Any liability insurance (eff. 4/97)
         (eff. 12/90 for carrier claims and 10/93
         for FI claims; obsoleted for all claim
         types 7/1/96)

     M = Override code:  EGHP services involved
         (eff. 12/90 for carrier claims and 10/93
         for FI claims; obsoleted for all claim
         types 7/1/96)

     N = Override code:  non-EGHP services involved
         (eff. 12/90 for carrier claims and 10/93
         for FI claims; obsoleted for all claim
         types 7/1/96)

     BLANK = Medicare is primary payer (not sure
             of effective date: in use 1/91, if
             not earlier)

     T = MSP cost avoided - IEQ contractor
         (eff. 7/96 carrier claims only)
     U = MSP cost avoided - HMO rate cell adjust-
```

```
                        ment contractor (eff. 7/96 carrier claims
                        only)
                V = MSP cost avoided - litigation settlement
                        contractor (eff. 7/96 carrier claims
                        only)

                X = MSP cost avoided override code (eff.
                        12/90 for carrier claims and 10/93 for
                        FI claims; obsoleted for all claim types
                        7/1/96)

                                ***Prior to 12/90***

                Y = Other secondary payer investigation
                        shows Medicare as primary payer
1      BENE_PRMRY_PYR_TB                  Beneficiary Primary Payer Table
       -----------------                  ------------------------------

                Z = Medicare is primary payer

                NOTE:  Values C, M, N, Y, Z and BLANK
                        indicate Medicare is primary payer.
                        (values Z and Y were used prior to
                        12/90.  BLANK was suppose to be
                        effective after 12/90, but may have
                        been used prior to that date.)

1         BETOS_TB                             BETOS Table
          --------                             -----------


                M1A = Office visits - new
                M1B = Office visits - established
                M2A = Hospital visit - initial
                M2B = Hospital visit - subsequent
                M2C = Hospital visit - critical care
                M3  = Emergency room visit
                M4A = Home visit
                M4B = Nursing home visit
                M5A = Specialist - pathology
                M5B = Specialist - psychiatry
                M5C = Specialist - opthamology
                M5D = Specialist - other
                M6  = Consultations
                P0  = Anesthesia
                P1A = Major procedure - breast
                P1B = Major procedure - colectomy
                P1C = Major procedure - cholecystectomy
                P1D = Major procedure - turp
                P1E = Major procedure - hysterctomy
                P1F = Major procedure - explor/decompr/excisdisc
                P1G = Major procedure - Other
                P2A = Major procedure, cardiovascular-CABG
                P2B = Major procedure, cardiovascular-Aneurysm repair
                P2C = Major Procedure, cardiovascular-Thromboendarterectomy
                P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
                P2E = Major procedure, cardiovascular-Pacemaker insertion
                P2F = Major procedure, cardiovascular-Other
```

```
                P3A = Major procedure, orthopedic - Hip fracture repair
                P3B = Major procedure, orthopedic - Hip replacement
                P3C = Major procedure, orthopedic - Knee replacement
                P3D = Major procedure, orthopedic - other
                P4A = Eye procedure - corneal transplant
                P4B = Eye procedure - cataract removal/lens insertion
                P4C = Eye procedure - retinal detachment
                P4D = Eye procedure - treatment
                P4E = Eye procedure - other
                P5A = Ambulatory procedures - skin
                P5B = Ambulatory procedures - musculoskeletal
                P5C = Ambulatory procedures - inguinal hernia repair
                P5D = Ambulatory procedures - lithotripsy
                P5E = Ambulatory procedures - other
                P6A = Minor procedures - skin
                P6B = Minor procedures - musculoskeletal
                P6C = Minor procedures - other (Medicare fee schedule)
                P6D = Minor procedures - other (non-Medicare fee schedule)
                P7A = Oncology - radiation therapy
                P7B = Oncology - other
                P8A = Endoscopy - arthroscopy
                P8B = Endoscopy - upper gastrointestinal
                P8C = Endoscopy - sigmoidoscopy
                P8D = Endoscopy - colonoscopy
                P8E = Endoscopy - cystoscopy
                P8F = Endoscopy - bronchoscopy
                P8G = Endoscopy - laparoscopic cholecystectomy
                P8H = Endoscopy - laryngoscopy
                P8I = Endoscopy - other
                P9A = Dialysis services
1          BETOS_TB                              BETOS Table
           --------                              -----------

                I1A = Standard imaging - chest
                I1B = Standard imaging - musculoskeletal
                I1C = Standard imaging - breast
                I1D = Standard imaging - contrast gastrointestinal
                I1E = Standard imaging - nuclear medicine
                I1F = Standard imaging - other
                I2A = Advanced imaging - CAT: head
                I2B = Advanced imaging - CAT: other
                I2C = Advanced imaging - MRI: brain
                I2D = Advanced imaging - MRI: other
                I3A = Echography - eye
                I3B = Echography - abdomen/pelvis
                I3C = Echography - heart
                I3D = Echography - carotid arteries
                I3E = Echography - prostate, transrectal
                I3F = Echography - other
                I4A = Imaging/procedure - heart including cardiac
                                          catheter
                I4B = Imaging/procedure - other
                T1A = Lab tests - routine venipuncture (non Medicare
                                  fee schedule)
                T1B = Lab tests - automated general profiles
                T1C = Lab tests - urinalysis
                T1D = Lab tests - blood counts
                T1E = Lab tests - glucose
```

```
                    T1F = Lab tests - bacterial cultures
                    T1G = Lab tests - other (Medicare fee schedule)
                    T1H = Lab tests - other (non-Medicare fee schedule)
                    T2A = Other tests - electrocardiograms
                    T2B = Other tests - cardiovascular stress tests
                    T2C = Other tests - EKG monitoring
                    T2D = Other tests - other
                    D1A = Medical/surgical supplies
                    D1B = Hospital beds
                    D1C = Oxygen and supplies
                    D1D = Wheelchairs
                    D1E = Other DME
                    D1F = Orthotic devices
                    O1A = Ambulance
                    O1B = Chiropractic
                    O1C = Enteral and parenteral
                    O1D = Chemotherapy
                    O1E = Other drugs
                    O1F = Vision, hearing and speech services
                    O1G = Influenza immunization
                    Y1  = Other - Medicare fee schedule
                    Y2  = Other - non-Medicare fee schedule
                    Z1  = Local codes
                    Z2  = Undefined codes

  1     CARR_CLM_PMT_DNL_TB                      Carrier Claim Payment Denial Table
        ------------------                       ----------------------------------


                    0 = Denied
                    1 = Physician/supplier
                    2 = Beneficiary
                    3 = Both physician/supplier and beneficiary
                    4 = Hospital (hospital based physicians)
                    5 = Both hospital and beneficiary
                    6 = Group practice prepayment plan
                    7 = Other entries (e.g. Employer, union)
                    8 = Federally funded
                    9 = PA service
                    A = Beneficiary under limitation of
                        liability
                    B = Physician/supplier under limitation of
                        liability
                    D = Denied due to demonstration involvement
                        (eff. 5/97)
                    E = MSP cost avoided IRS/SSA/HCFA Data
                        Match (eff. 7/3/00)
                    F = MSP cost avoided HMO Rate Cell
                        (eff. 7/3/00)
                    G = MSP cost avoided Litigation Settlement
                        (eff. 7/3/00)
                    H = MSP cost avoided Employer Voluntary
                        Reporting (eff. 7/3/00)
                    J = MSP cost avoided Insurer Voluntary
                        Reporting (eff. 7/3/00)
                    K = MSP cost avoided Initial Enrollment
                        Questionnaire (eff. 7/3/00)
                    P = Physician ownership denial (eff 3/92)
```

```
        Q = MSP cost avoided - (Contractor #88888)
            voluntary agreement (eff. 1/98)
        T = MSP cost avoided - IEQ contractor
            (eff. 7/96) (obsolete 6/30/00)
        U = MSP cost avoided - HMO rate cell
            adjustment (eff. 7/96) (obsolete 6/30/00)
        V = MSP cost avoided - litigation
            settlement (eff. 7/96) (obsolete 6/30/00)
        X = MSP cost avoided - generic
        Y = MSP cost avoided - IRS/SSA data
            match project (obsolete 6/30/00)


1   CARR_LINE_PRVDR_TYPE_TB                     Carrier Line Provider Type Table
    ----------------------                      --------------------------------


        For Physician/Supplier (RIC O) Claims:

        0 = Clinics, groups, associations,
            partnerships, or other entities
        1 = Physicians or suppliers reporting as
            solo practitioners
        2 = Suppliers (other than sole proprietorship)
        3 = Institutional provider
        4 = Independent laboratories
        5 = Clinics (multiple specialties)
        6 = Groups (single specialty)
        7 = Other entities

        For DMERC (RIC M) Claims - PRIOR TO VERSION H:

        0 = Clinics, groups, associations,
            partnerships, or other entities
            for whom the carrier's own ID number
            has been assigned.
        1 = Physicians or suppliers billing as
            solo practitioners for whom SSN's are
            shown in the physician ID code field.
        2 = Physicians or suppliers billing as
            solo practitioners for whom the carrier's
            own physician ID code is shown.
        3 = Suppliers (other than sole proprietorship)
            for whom EI numbers are used in coding the
            ID field.
        4 = Suppliers (other than sole proprietorship)
            for whom the carrier's own code has been
            shown.
        5 = Institutional providers and
            independent laboratories for whom EI
            numbers are used in coding the ID field.
        6 = Institutional providers and
            independent laboratories for whom the
            carrier's own ID number is shown.
        7 = Clinics, groups, associations, or
            partnerships for whom EI numbers
            are used in coding the ID field.
        8 = Other entities for whom EI numbers
            are used in coding the ID field or
```

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                          proprietorship for whom EI numbers are
                          used in coding the ID field.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB          Carrier Line Part B Reduced Physician Assistant Table
 ----------------------------           ----------------------------------------------------


                          BLANK = Adjustment situation (where
                                  CLM_DISP_CD equal 3)
                          0 = N/A
                          1 = 65%
                              A) Physician assistants assisting in
                                 surgery
                              B) Nurse midwives
                          2 = 75%
                              A) Physician assistants performing
                                 services in a hospital (other than
                                 assisting surgery)
                              B) Nurse practitioners and clinical
                                 nurse specialists performing
                                 services in rural areas
                              C) Clinical social worker services
                          3 = 85%
                              A) Physician assistant services for
                                 other than assisting surgery
                              B) Nurse practitioners services


1       CARR_NUM_TB                          Carrier Number Table
        -----------                          --------------------


                          00510 = Alabama BS (eff. 1983)
                          00511 = Georgia - Alabama BS (eff. 1998)
                          00512 = Mississippi - Alabama BS (eff. 2000)
                          00520 = Arkansas BS (eff. 1983)
                          00521 = New Mexico - Arkansas BS (eff. 1998)
                          00522 = Oklahoma - Arkansas BS (eff. 1998)
                          00523 = Missouri - Arkansas BS (eff. 1999)
                          00528 = Louisianna - Arkansas BS (eff. 1984)
                          00542 = California BS (eff. 1983; term. 1996)
                          00550 = Colorado BS (eff. 1983; term. 1994)
                          00570 = Delaware - Pennsylvania BS (eff. 1983;
                                    term. 1997)
                          00580 = District of Columbia - Pennsylvania BS
                                    (eff. 1983; term. 1997)
                          00590 = Florida BS (eff. 1983)
                          00591 = Connecticut - Florida BS (eff. 2000)
                          00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
                          00623 = Michigan - Illinois Blue Shield (eff. 1995)
                                    (term. 1998)
                          00630 = Indiana - Administar (eff. 1983)
                          00635 = DMERC-B (Administar Federal, Inc.)
                                    (eff. 1993)
                          00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
                          00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
                          00650 = Kansas BS (eff. 1983)
                          00655 = Nebraska - Kansas BS (eff. 1988)
                          00660 = Kentucky - Administar (eff. 1983)
```

```
                    00690 = Maryland BS (eff. 1983; term. 1994)
                    00700 = Massachusetts BS (eff. 1983; term. 1997)
                    00710 = Michigan BS (eff. 1983; term. 1994)
                    00720 = Minnesota BS (eff. 1983; term. 1995)
                    00740 = Missouri - BS Kansas City (eff. 1983)
                    00751 = Montana BS (eff. 1983)
                    00770 = New Hampshire/Vermont Physician Services
                            (eff. 1983; term. 1984)
                    00780 = New Hampshire/Vermont - Massachusetts BS
                            (eff. 1985; term. 1997)
                    00801 = New York - Western BS (eff. 1983)
                    00803 = New York - Empire BS (eff. 1983)
                    00805 = New Jersey - Empire BS (eff. 3/99)
                    00811 = DMERC (A) - Western New York BS (eff. 2000)
                    00820 = North Dakota - North Dakota BS (eff. 1983)
                    00824 = Colorado - North Dakota BS (eff. 1995)
                    00825 = Wyoming - North Dakota BS (eff. 1990)
                    00826 = Iowa - North Dakota BS (eff. 1999)
                    00831 = Alaska - North Dakota BS (eff. 1998)
                    00832 = Arizona -  North Dakota BS (eff. 1998)
                    00833 = Hawaii - North Dakota BS (eff. 1998)
                    00834 = Nevada - North Dakota BS (eff. 1998)
                    00835 = Oregon - North Dakota BS (eff. 1998)
                    00836 = Washington - North Dakota BS (eff. 1998)
                    00860 = New Jersey - Pennsylvania BS (eff. 1988;
                            term. 1999)
                    00865 = Pennsylvania BS (eff. 1983)
                    00870 = Rhode Island BS (eff. 1983)
                    00880 = South Carolina BS (eff. 1983)
                    00882 = RRB - South Carolina PGBA (eff. 2000)
1       CARR_NUM_TB                              Carrier Number Table
        -----------                              --------------------

                    00885 = DMERC C - Palmetto (eff. 1993)
                    00900 = Texas BS (eff. 1983)
                    00901 = Maryland - Texas BS (eff. 1995)
                    00902 = Delaware - Texas BS (eff. 1998)
                    00903 = District of Columbia - Texas BS (eff. 1998)
                    00904 = Virginia - Texas BS (eff. 2000)
                    00910 = Utah  BS (eff. 1983)
                    00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
                    00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
                    00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
                    00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
                    00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
                    00974 = Triple-S, Inc. - Virgin Islands
                    01020 = Alaska - AETNA (eff. 1983; term. 1997)
                    01030 = Arizona - AETNA (eff. 1983; term. 1997)
                    01040 = Georgia - AETNA (eff. 1988; term. 1997)
                    01120 = Hawaii - AETNA (eff. 1983; term. 1997)
                    01290 = Nevada - AETNA (eff. 1983; term. 1997)
                    01360 = New Mexico - AETNA (eff. 1986; term. 1997)
                    01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
                    01380 = Oregon - AETNA (eff. 1983; term. 1997
                    01390 = Washington - AETNA (eff. 1994; term. 1997)
                    02050 = California - TOLIC (eff. 1983)
                            (term. 2000)
                    03070 = Connecticut General Life Insurance Co.
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                              (eff. 1983; term. 1985)
              05130 = Idaho - Connecticut General (eff. 1983)
              05320 = New Mexico - Equitable Insurance
                      (eff. 1983; term. 1985)
              05440 = Tennessee - Connecticut General (eff. 1983)
              05530 = Wyoming - Equitable Insurance (eff. 1983)
                      (term. 1989)
              05535 = North Carolina - Connecticut General
                      (eff. 1988)
              05655 = DMERC-D - Connecticut General (eff. 1993)
              10071 = Railroad Board Travelers (eff. 1983)
                      (term. 2000)
              10230 = Connecticut - Metra Health (eff. 1986)
                      (term. 2000)
              10240 = Minnesota - Metra Health (eff. 1983)
                      (term. 2000)
              10250 = Mississippi - Metra Health (eff. 1983)
                      (term. 2000)
              10490 = Virginia - Metra Health (eff. 1983)
                      (term. 2000)
              10555 = Travelers Insurance Co. (eff. 1993)
                      (term. 2000)
              11260 = Missouri - General American Life
                      (eff. 1983; term. 1998)
              14330 = New York - GHI (eff. 1983)
              16360 = Ohio - Nationwide Insurance Co.
              16510 = West Virginia - Nationwide Insurance Co.
              21200 = Maine - BS of Massachusetts
              31140 = California - National Heritage Ins.
              31142 = Maine - National Heritage Ins.
              31143 = Massachusetts - National Heritage Ins.
              31144 = New Hampshire - National Heritage Ins.
              31145 = Vermont - National Heritage Ins.
1     CARR_NUM_TB                         Carrier Number Table
      -----------                         --------------------

              31146 = So. California - NHIC (eff. 2000)

1     CLM_BILL_TYPE_TB                    Claim Bill Type Table
      ----------------                    ---------------------


              11 = Hospital-inpatient (including Part A)
              12 = Hospital-inpatient or home health visits (Part B only)
              13 = Hospital-outpatient (HHA-A also) (under OPPS 13X
                   must be used for ASC claims submitted for OPPS
                   payment -- eff. 7/00)
              14 = Hospital-other (Part B)
              15 = Hospital-intermediate care - level I
              16 = Hospital-intermediate care - level II
              17 = Hospital-intermediate care - level III
              18 = Hospital-swing beds
              19 = Hospital-reserved for national assignment
              21 = SNF-inpatient (including Part A)
              22 = SNF-inpatient or home health visits (Part B only)
              23 = SNF-outpatient (HHA-A also)
              24 = SNF-other (Part B)
              25 = SNF-intermediate care - level I
```

```
                    26 = SNF-intermediate care - level II
                    27 = SNF-intermediate care - level III
                    28 = SNF-swing beds
                    29 = SNF-reserved for national assignment
                    31 = HHA-inpatient (including Part A)
                    32 = HHA-inpatient or home health visits (Part B only)
                    33 = HHA-outpatient (HHA-A also)
                    34 = HHA-other (Part B)
                    35 = HHA-intermediate care - level I
                    36 = HHA-intermediate care - level II
                    37 = HHA-intermediate care - level III
                    38 = HHA-swing beds
                    39 = HHA-reserved for national assignment
                    41 = Religious Nonmedical Health Care Institution (RNHCI)
                         hospital-inpatient (including Part A) (all references
                         to Christian Science (CS) is obsolete eff. 8/00 and
                         replaced with RNHCI)
                    42 = RNHCI hospital-inpatient or home health visits (Part B only)
                    43 = RNHCI hospital-outpatient (HHA-A also)
                    44 = RNHCI hospital-other (Part B)
                    45 = RNHCI hospital-intermediate care - level I
                    46 = RNHCI hospital-intermediate care - level II
                    47 = RNHCI hospital-intermediate care - level III
                    48 = RNHCI hospital-swing beds
                    49 = RNHCI hospital-reserved for national assignment
                    51 = CS extended care-inpatient (including Part A) OBSOLETE
                         eff. 7/00 - implementation of Religious Nonmedical
                         Health Care Institutions (RNHCI)
                    52 = RNHCI extended care-inpatient or home health visits
                         (Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
                    53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
                         prior to 7/00 referenced CS
                    54 = RNHCI extended care-other (Part B)(eff. 7/00); prior
                         to 7/00 referenced CS
                    55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
                         prior to 7/00 referenced CS
                    56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
                         prior to 7/00 referenced CS
                    57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
                         prior to 7/00 referenced CS
                    58 = RNHCI extended care-swing beds (eff. 7/00)
1     CLM_BILL_TYPE_TB                          Claim Bill Type Table
      ----------------                          ---------------------

                         prior to 7/00 referenced CS
                    59 = RNHCI extended care-reserved for national assignment
                         (eff. 7/00); prior to 7/00 referenced CS
                    61 = Intermediate care-inpatient (including Part A)
                    62 = Intermediate care-inpatient or home health visits (Part B only)
                    63 = Intermediate care-outpatient (HHA-A also)
                    64 = Intermediate care-other (Part B)
                    65 = Intermediate care-intermediate care - level I
                    66 = Intermediate care-intermediate care - level II
                    67 = Intermediate care-intermediate care - level III
                    68 = Intermediate care-swing beds
                    69 = Intermediate care-reserved for national assignment
                    71 = Clinic-rural health
                    72 = Clinic-hospital based or independent renal dialysis facility
```

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                 73 = Clinic-independent provider based FQHC (eff 10/91)
                 74 = Clinic-ORF only (eff 4/97);
                      ORF and CMHC (10/91 - 3/97)
                 75 = Clinic-CORF
                 76 = Clinic-CMHC (eff 4/97)
                 77 = Clinic-reserved for national assignment
                 78 = Clinic-reserved for national assignment
                 79 = Clinic-other
                 81 = Special facility or ASC surgery-hospice (non-hospital based)
                 82 = Special facility or ASC surgery-hospice (hospital based)
                 83 = Special facility or ASC surgery-ambulatory surgical center
                      (Discontinued for Hospitals Subject to Outpatient PPS;
                       hospitals must use 13X for ASC claims submitted for OPPS
                       payment -- eff. 7/00)
                 84 = Special facility or ASC surgery-freestanding birthing center
                 85 = Special facility or ASC surgery-rural primary care hospital (eff
                 86 = Special facility or ASC surgery-reserved for national use
                 87 = Special facility or ASC surgery-reserved for national use
                 88 = Special facility or ASC surgery-reserved for national use
                 89 = Special facility or ASC surgery-other
                 91 = Reserved-inpatient (including Part A)
                 92 = Reserved-inpatient or home health visits (Part B only)
                 93 = Reserved-outpatient (HHA-A also)
                 94 = Reserved-other (Part B)
                 95 = Reserved-intermediate care - level I
                 96 = Reserved-intermediate care - level II
                 97 = Reserved-intermediate care - level III
                 98 = Reserved-swing beds
                 99 = Reserved-reserved for national assignment

1      CLM_DISP_TB                            Claim Disposition Table
       -----------                            -----------------------


                 01 = Debit accepted
                 02 = Debit accepted (automatic adjustment)
                      applicable through 4/4/93
                 03 = Cancel accepted
                 61 = *Conversion code: debit accepted
                 62 = *Conversion code: debit accepted
                       (automatic adjustment)
                 63 = *Conversion code: cancel accepted

                    *Used only during conversion period:
                         1/1/91 - 2/21/91

1      CLM_FAC_TYPE_TB                        Claim Facility Type Table
       ---------------                        -------------------------


                 1 = Hospital
                 2 = Skilled nursing facility (SNF)
                 3 = Home health agency (HHA)
                 4 = Religious Nonmedical (Hospital)
                     (eff. 8/1/00); prior to 8/00 referenced Christian
                     Science (CS)
                 5 = Religious Nonmedical (Extended Care)
                     (eff. 8/1/00); prior to 8/00 referenced CS
```

```
                        6 = Intermediate care
                        7 = Clinic or hospital-based renal dialysis facility
                        8 = Special facility or ASC surgery
                        9 = Reserved

1       CLM_FREQ_TB                             Claim Frequency Table
        -----------                             --------------------


                        0 = Non-payment/zero claims
                        1 = Admit thru discharge claim
                        2 = Interim - first claim
                        3 = Interim - continuing claim
                        4 = Interim - last claim
                        5 = Late charge(s) only claim
                        6 = Adjustment of prior claim
                        7 = Replacement of prior claim;
                            eff 10/93, provider debit
                        8 = Void/cancel prior claim.
                            eff 10/93, provider cancel
                        9 = Final claim -- used in an HH PPS
                            episode to indicate the claim
                            should be processed like debit/
                            credit adjustment to RAP (initial
                            claim) (eff. 10/00)
                        A = Admission notice - used when hospice
                            is submitting the HCFA-1450 as an
                            admission notice - hospice NOE only
                        B = Hospice termination/revocation notice
                            - hospice NOE only  (eff 9/93)
                        C = Hospice change of provider notice
                            - hospice NOE only (eff 9/93)
                        D = Hospice election void/cancel
                            - hospice NOE only  (eff 9/93)
                        E = Hospice change of ownership
                            - hospice NOE only  (eff 1/97)
                        F = Beneficiary initiated adjustment
                            (eff 10/93)
                        G = CWF generated adjustment (eff 10/93)
                        H = HCFA generated adjustment (eff 10/93)
                        I = Misc adjustment claim (other than PRO
                            or provider) - used to identify a
                            debit adjustment initiated by HCFA or
                            an intermediary - eff 10/93, used to
                            identify intermediary initiated
                            adjustment only
                        J = Other adjustment request (eff 10/93)
                        K = OIG initiated adjustment (eff 10/93)
                        M = MSP adjustment (eff 10/93)
                        P = Adjustment required by peer review
                            organization (PRO)
                        X = Special adjustment processing - used
                            for QA editing (eff 8/92)
                        Z = Hospital Encounter Data alternate sub-
                            mission (TOB '11Z') used for MCO enrollee
                            hospital discharges 7/1/97-12/31/98; not
                            stored in NCH.  Exception:  Problem in
                            startup months may have resulted in this
```

```
                          abbreviated UB-92 being erroneously
                          stored in NCH.

1     CLM_HHA_RFRL_TB                          Claim Home Health Referral Table
      ---------------                          ------------------------------


              1 = Physician referral - The patient was
                  admitted upon the recommendation of
                  a personal physician.
              2 = Clinic referral - The patient was
                  admitted upon the recommendation of
                  this facility's clinic physician.
              3 = HMO referral - The patient was admitted
                  upon the recommendation of an health
                  maintenance organization (HMO)
                  physician.
              4 = Transfer from hospital - The patient
                  was admitted as an inpatient transfer
                  from an acute care facility.
              5 = Transfer from a skilled nursing
                  facility (SNF) - The patient was
                  admitted as an inpatient transfer
                  from a SNF.
              6 = Transfer from another health care
                  facility - The patient was admitted
                  as a transfer from a health care
                  facility other than an acute care
                  facility or SNF.
              7 = Emergency room - The patient was
                  admitted upon the recommendation of
                  this facility's emergency room
                  physician.
              8 = Court/law enforcement - The patient was
                  admitted upon the direction of a
                  court of law or upon the request of
                  a law enforcement agency's
                  representative.
              9 = Information not available -  The means
                  by which the patient was admitted is
                  not known.
              A = Transfer from a Critical Access Hospital -
                  patient was admitted/referred to this
                  facility as a transfer from a Critical
                  Access Hospital.
              B = Transfer from another HHA - Beneficiaries
                  are permitted to transfer from one HHA
                  to another unrelated HHA under HH PPS.
                  (eff. 10/00)
              C = Readmission to same HHA - If a beneficiary
                  is discharged from an HHA and then re-
                  admitted within the original 60-day
                  episode, the original episode must be
                  closed early and a new once created.
                  NOTE: the use of this code will permit
                  the agency to send a new RAP allowing
                  all claims to  be accepted by Medicare.
                  (eff. 10/00)
```

```
******************  SNF PPS HIPPS **************************
**************1st 3 positions (RUGS-III group)**************
AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g.,
                    physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions
CC1,CC2           (e.g., chemo, dialysis)

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-
                    paired cognition (e.g., short-
                    term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions
PC1,PC2,PD1,PD2
PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation
RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = Very high/ultra high rehabilita-
RVB,RVC           tion: highest level

SE1,SE2,SE3     = Extensive services; e.g.; IV feed
                   trach care

SSA,SSB,SSC     = Special care; e.g.; coma, burns

***********Positions 4 & 5 represent HIPPS modifier/********
*************** assessment type indicator ******************

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial
     admission assessment
02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment
     (eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/
     not an initial admission assessment
08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/
     return) assessment
17 = Medicare 14-day required assessment AND initial
     admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment
     (eff. 10/2000)
28 = OMRA replacing Medicare 30-day required assessment
     (eff. 10/2000)
30 = Off-cycle significant change assessment (outside
     assessment window) (eff. 10/2000)
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                              31 = Significant change assessment replaces Medicare
                                   5-day assessment (eff. 10/2000)
                              32 = Significant change assessment replaces Medicare
                                   30-day assessment
1        CLM_HIPPS_TB             Claim SNF & HHA Health Insurance       PPS Table
         ------------             ------------------------------------------------

                              33 = Significant change assessment replaces Medicare
                                   6--day assessment
                              34 = Significant change assessment replaces Medicare
                                   90-day assessment
                              35 = Significant change assessment replaces a Medicare
                                   readmission/return assessment
                              37 = Significant change assessment replaces Medicare
                                   14-day assessment
                              38 = OMRA replacing Medicare 60-day required
                                   assessment
                              40 = Off-cycle significant correction assessment of a
                                   prior assessment (outside assessment window)
                                   (eff. 10/2000)
                              41 = Significant correction of prior full assessment
                                   replaces a Medicare 5-day assessment
                              42 = Significant correction of prior full assessment
                                   replaces a Medicare 30-day assessment
                              43 = Significant correction of prior full assessment
                                   replaces a Medicare 60-day assessment
                              44 = Significant correction of prior full assessment
                                   replaces a Medicare 90-day assessment
                              45 = Significant correction of a prior assessment
                                   replaces a readmission/return assessment
                                   (eff. 10/2000)
                              47 = Significant correction of prior full assessment
                                   replaces a Medicare 14-day required assessment
                              48 = OMRA replacing Medicare 90-day required assessment
                              54 = Quarterly review assessment - Medicare 90-day
                                   full assessment
                              78 = OMRA replacing a Medicare 14-day assessment
                                   (eff. 10/2000)

                              ****************************************************************
                              ****************************************************************


                              *************Claim Home Health PPS HIPPS Table****************
                              ************************* KEY ********************************
                              Position 1 = 'H'
                              Position 2 = Clinical (A, B, C, D)
                              Position 3 = Functional (E, F, G, H, I)
                              Position 4 = Service (J, K, K, M)
                              Position 5 = identifies which elements of the code were
                                           computed or derived:
                                           1 = 2nd, 3rd, 4th positions computed
                                           2 = 2nd position derived
                                           3 = 3rd position derived
                                           4 = 4th position derived
                                           5 = 2nd & 3rd positions derived
                                           6 = 3rd & 4th positions derived
                                           7 = 2nd & 4th positions derived
```

```
                            8 = 2nd, 3rd, 4th positions derived
                       *****************************************************************

                       **HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min**
                       HAEJ1
                       HAEJ2
                       HAEJ3
1         CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
          ------------              -------------------------------------------------

                       HAEJ4
                       HAEJ5
                       HAEJ6
                       HAEJ7
                       HAEJ8
                       **HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low**
                       HAEK1
                       HAEK2
                       HAEK3
                       HAEK4
                       HAEK5
                       HAEK6
                       HAEK7
                       HAEK8
                       **HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod**
                       HAEL1
                       HAEL2
                       HAEL3
                       HAEL4
                       HAEL5
                       HAEL6
                       HAEL7
                       HAEL8
                       **HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High**
                       HAEM1
                       HAEM2
                       HAEM3
                       HAEM4
                       HAEM5
                       HAEM6
                       HAEM7
                       HAEM8
                       **HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min**
                       HAFJ1
                       HAFJ2
                       HAFJ3
                       HAFJ4
                       HAFJ5
                       HAFJ6
                       HAFJ7
                       HAFJ8
                       **HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low**
                       HAFK1
                       HAFK2
                       HAFK3
                       HAFK4
                       HAFK5
                       HAFK6
```

```
                                  HAFK7
                                  HAFK8
                                  **HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod**
                                  HAFL1
                                  HAFL2
                                  HAFL3
                                  HAFL4
                                  HAFL5
                                  HAFL6
                                  HAFL7
1          CLM_HIPPS_TB                   Claim SNF & HHA Health Insurance     PPS Table
           ------------                   -------------------------------------------------

                                  HAFL8
                                  **HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High**
                                  HAFM1
                                  HAFM2
                                  HAFM3
                                  HAFM4
                                  HAFM5
                                  HAFM6
                                  HAFM7
                                  HAFM8
                                  **HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min**
                                  HAGJ1
                                  HAGJ2
                                  HAGJ3
                                  HAGJ4
                                  HAGJ5
                                  HAGJ6
                                  HAGJ7
                                  HAGJ8
                                  **HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low**
                                  HAGK1
                                  HAGK2
                                  HAGK3
                                  HAGK4
                                  HAGK5
                                  HAGK6
                                  HAGK7
                                  HAGK8
                                  **HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod**
                                  HAGL1
                                  HAGL2
                                  HAGL3
                                  HAGL4
                                  HAGL5
                                  HAGL6
                                  HAGL7
                                  HAGL8
                                  **HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High**
                                  HAGM1
                                  HAGM2
                                  HAGM3
                                  HAGM4
                                  HAGM5
                                  HAGM6
                                  HAGM7
```

```
                                HAGM8
                                **HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min**
                                HAHJ1
                                HAHJ2
                                HAHJ3
                                HAHJ4
                                HAHJ5
                                HAHJ6
                                HAHJ7
                                HAHJ8
                                **HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low**
                                HAHK1
                                HAHK2
1        CLM_HIPPS_TB                Claim SNF & HHA Health Insurance      PPS Table
         ------------                ------------------------------------------------

                                HAHK3
                                HAHK4
                                HAHK5
                                HAHK6
                                HAHK7
                                HAHK8
                                **HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod**
                                HAHL1
                                HAHL2
                                HAHL3
                                HAHL4
                                HAHL5
                                HAHL6
                                HAHL7
                                HAHL8
                                **HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High**
                                HAHM1
                                HAHM2
                                HAHM3
                                HAHM4
                                HAHM5
                                HAHM6
                                HAHM7
                                HAHM8
                                **HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min**
                                HAIJ1
                                HAIJ2
                                HAIJ3
                                HAIJ4
                                HAIJ5
                                HAIJ6
                                HAIJ7
                                HAIJ8
                                **HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low**
                                HAIK1
                                HAIK2
                                HAIK3
                                HAIK4
                                HAIK5
                                HAIK6
                                HAIK7
                                HAIK8
```

```
                              **HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod**
                              HAIL1
                              HAIL2
                              HAIL3
                              HAIL4
                              HAIL5
                              HAIL6
                              HAIL7
                              HAIL8
                              **HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High**
                              HAIM1
                              HAIM2
                              HAIM3
                              HAIM4
                              HAIM5
                              HAIM6
1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance       PPS Table
         ------------                 ------------------------------------------------

                              HAIM7
                              HAIM8
                              **HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min**
                              HBEJ1
                              HBEJ2
                              HBEJ3
                              HBEJ4
                              HBEJ5
                              HBEJ6
                              HBEJ7
                              HBEJ8
                              **HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low**
                              HBEK1
                              HBEK2
                              HBEK3
                              HBEK4
                              HBEK5
                              HBEK6
                              HBEK7
                              HBEK8
                              **HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod**
                              HBEL1
                              HBEL2
                              HBEL3
                              HBEL4
                              HBEL5
                              HBEL6
                              HBEL7
                              HBEL8
                              **HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High**
                              HBEM1
                              HBEM2
                              HBEM3
                              HBEM4
                              HBEM5
                              HBEM6
                              HBEM7
                              HBEM8
                              **HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min**
```

```
                                HBFJ1
                                HBFJ2
                                HBFJ3
                                HBFJ4
                                HBFJ5
                                HBFJ6
                                HBFJ7
                                HBFJ8
                                **HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low**
                                HBFK1
                                HBFK2
                                HBFK3
                                HBFK4
                                HBFK5
                                HBFK6
                                HBFK7
                                HBFK8
                                **HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod**
                                HBFL1
1       CLM_HIPPS_TB            Claim SNF & HHA Health Insurance      PPS Table
        ------------           ------------------------------------------------

                                HBFL2
                                HBFL3
                                HBFL4
                                HBFL5
                                HBFL6
                                HBFL7
                                HBFL8
                                **HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High**
                                HBFM1
                                HBFM2
                                HBFM3
                                HBFM4
                                HBFM5
                                HBFM6
                                HBFM7
                                HBFM8
                                **HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min**
                                HBGJ1
                                HBGJ2
                                HBGJ3
                                HBGJ4
                                HBGJ5
                                HBGJ6
                                HBGJ7
                                HBGJ8
                                **HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low**
                                HBGK1
                                HBGK2
                                HBGK3
                                HBGK4
                                HBGK5
                                HBGK6
                                HBGK7
                                HBGK8
                                **HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod**
                                HBGL1
```

```
                                    HBGL2
                                    HBGL3
                                    HBGL4
                                    HBGL5
                                    HBGL6
                                    HBGL7
                                    HBGL8
                                    **HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High**
                                    HBGM1
                                    HBGM2
                                    HBGM3
                                    HBGM4
                                    HBGM5
                                    HBGM6
                                    HBGM7
                                    HBGM8
                                    **HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min**
                                    HBHJ1
                                    HBHJ2
                                    HBHJ3
                                    HBHJ4
                                    HBHJ5
1       CLM_HIPPS_TB                    Claim SNF & HHA Health Insurance       PPS Table
        ------------                    ----------------------------------------------

                                    HBHJ6
                                    HBHJ7
                                    HBHJ8
                                    **HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low**
                                    HBHK1
                                    HBHK2
                                    HBHK3
                                    HBHK4
                                    HBHK5
                                    HBHK6
                                    HBHK7
                                    HBHK8
                                    **HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod**
                                    HBHL1
                                    HBHL2
                                    HBHL3
                                    HBHL4
                                    HBHL5
                                    HBHL6
                                    HBHL7
                                    HBHL8
                                    **HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High**
                                    HBHM1
                                    HBHM2
                                    HBHM3
                                    HBHM4
                                    HBHM5
                                    HBHM6
                                    HBHM7
                                    HBHM8
                                    **HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min**
                                    HBIJ1
                                    HBIJ2
```

```
                              HBIJ3
                              HBIJ4
                              HBIJ5
                              HBIJ6
                              HBIJ7
                              HBIJ8
                              **HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low**
                              HBIK1
                              HBIK2
                              HBIK3
                              HBIK4
                              HBIK5
                              HBIK6
                              HBIK7
                              HBIK8
                              **HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod**
                              HBIL1
                              HBIL2
                              HBIL3
                              HBIL4
                              HBIL5
                              HBIL6
                              HBIL7
                              HBIL8
                              **HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High**
1          CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
           ------------              --------------------------------------------------

                              HBIM1
                              HBIM2
                              HBIM3
                              HBIM4
                              HBIM5
                              HBIM6
                              HBIM7
                              HBIM8
                              **HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min**
                              HCEJ1
                              HCEJ2
                              HCEJ3
                              HCEJ4
                              HCEJ5
                              HCEJ6
                              HCEJ7
                              HCEJ8
                              **HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low**
                              HCEK1
                              HCEK2
                              HCEK3
                              HCEK4
                              HCEK5
                              HCEK6
                              HCEK7
                              HCEK8
                              **HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod**
                              HCEL1
                              HCEL2
                              HCEL3
```

```
                                HCEL4
                                HCEL5
                                HCEL6
                                HCEL7
                                HCEL8
                                **HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High**
                                HCEM1
                                HCEM2
                                HCEM3
                                HCEM4
                                HCEM5
                                HCEM6
                                HCEM7
                                HCEM8
                                **HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min**
                                HCFJ1
                                HCFJ2
                                HCFJ3
                                HCFJ4
                                HCFJ5
                                HCFJ6
                                HCFJ7
                                HCFJ8
                                **HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod**
                                HCFL1
                                HCFL2
                                HCFL3
                                HCFL4
1       CLM_HIPPS_TB                Claim SNF & HHA Health Insurance      PPS Table
        ------------                --------------------------------------------------

                                HCFL5
                                HCFL6
                                HCFL7
                                HCFL8
                                **HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High**
                                HCFM1
                                HCFM2
                                HCFM3
                                HCFM4
                                HCFM5
                                HCFM6
                                HCFM7
                                HCFM8
                                **HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min**
                                HCGJ1
                                HCGJ2
                                HCGJ3
                                HCGJ4
                                HCGJ5
                                HCGJ6
                                HCGJ7
                                HCGJ8
                                **HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low**
                                HCGK1
                                HCGK2
                                HCGK3
                                HCGK4
```

```
                                    HCGK5
                                    HCGK6
                                    HCGK7
                                    HCGK8
                                    **HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod**
                                    HCGL1
                                    HCGL2
                                    HCGL3
                                    HCGL4
                                    HCGL5
                                    HCGL6
                                    HCGL7
                                    HCGL8
                                    **HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High**
                                    HCGM1
                                    HCGM2
                                    HCGM3
                                    HCGM4
                                    HCGM5
                                    HCGM6
                                    HCGM7
                                    HCGM8
                                    **HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min**
                                    HCHJ1
                                    HCHJ2
                                    HCHJ3
                                    HCHJ4
                                    HCHJ5
                                    HCHJ6
                                    HCHJ7
                                    HCHJ8
1       CLM_HIPPS_TB                        Claim SNF & HHA Health Insurance      PPS Table
        ------------                        ------------------------------------------------

                                    **HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low**
                                    HCHK1
                                    HCHK2
                                    HCHK3
                                    HCHK4
                                    HCHK5
                                    HCHK6
                                    HCHK7
                                    HCHK8
                                    **HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod**
                                    HCHL1
                                    HCHL2
                                    HCHL3
                                    HCHL4
                                    HCHL5
                                    HCHL6
                                    HCHL7
                                    HCHL8
                                    **HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High**
                                    HCHM1
                                    HCHM2
                                    HCHM3
                                    HCHM4
                                    HCHM5
```

```
                                        HCHM6
                                        HCHM7
                                        HCHM8
                                        **HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min**
                                        HCIJ1
                                        HCIJ2
                                        HCIJ3
                                        HCIJ4
                                        HCIJ5
                                        HCIJ6
                                        HCIJ7
                                        HCIJ8
                                        **HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low**
                                        HCIK1
                                        HCIK2
                                        HCIK3
                                        HCIK4
                                        HCIK5
                                        HCIK6
                                        HCIK7
                                        HCIK8
                                        **HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod**
                                        HCIL1
                                        HCIL2
                                        HCIL3
                                        HCIL4
                                        HCIL5
                                        HCIL6
                                        HCIL7
                                        HCIL8
                                        **HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High**
                                        HCIM1
                                        HCIM2
                                        HCIM3
1         CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
          ------------              ------------------------------------------------

                                        HCIM4
                                        HCIM5
                                        HCIM6
                                        HCIM7
                                        HCIM8
                                        **HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min**
                                        HDEJ1
                                        HDEJ2
                                        HDEJ3
                                        HDEJ4
                                        HDEJ5
                                        HDEJ6
                                        HDEJ7
                                        HDEJ8
                                        **HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low**
                                        HDEK1
                                        HDEK2
                                        HDEK3
                                        HDEK4
                                        HDEK5
                                        HDEK6
```

```
                                  HDEK7
                                  HDEK8
                                  **HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod**
                                  HDEL1
                                  HDEL2
                                  HDEL3
                                  HDEL4
                                  HDEL5
                                  HDEL6
                                  HDEL7
                                  HDEL8
                                  **HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High**
                                  HDEM1
                                  HDEM2
                                  HDEM3
                                  HDEM4
                                  HDEM5
                                  HDEM6
                                  HDEM7
                                  HDEM8
                                  **HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min**
                                  HDFJ1
                                  HDFJ2
                                  HDFJ3
                                  HDFJ4
                                  HDFJ5
                                  HDFJ6
                                  HDFJ7
                                  HDFJ8
                                  **HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low**
                                  HDFK1
                                  HDFK2
                                  HDFK3
                                  HDFK4
                                  HDFK5
                                  HDFK6
                                  HDFK7
1        CLM_HIPPS_TB                     Claim SNF & HHA Health Insurance      PPS Table
         ------------                     ------------------------------------------------

                                  HDFK8
                                  **HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod**
                                  HDFL1
                                  HDFL2
                                  HDFL3
                                  HDFL4
                                  HDFL5
                                  HDFL6
                                  HDFL7
                                  HDFL8
                                  **HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High**
                                  HDFM1
                                  HDFM2
                                  HDFM3
                                  HDFM4
                                  HDFM5
                                  HDFM6
                                  HDFM7
```

```
                                  HDFM8
                                  **HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min**
                                  HDGJ1
                                  HDGJ2
                                  HDGJ3
                                  HDGJ4
                                  HDGJ5
                                  HDGJ6
                                  HDGJ7
                                  HDGJ8
                                  **HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low**
                                  HDGK1
                                  HDGK2
                                  HDGK3
                                  HDGK4
                                  HDGK5
                                  HDGK6
                                  HDGK7
                                  HDGK8
                                  **HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod**
                                  HDGL1
                                  HDGL2
                                  HDGL3
                                  HDGL4
                                  HDGL5
                                  HDGL6
                                  HDGL7
                                  HDGL8
                                  **HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High**
                                  HDGM1
                                  HDGM2
                                  HDGM3
                                  HDGM4
                                  HDGM5
                                  HDGM6
                                  HDGM7
                                  HDGM8
                                  **HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min**
                                  HDHJ1
                                  HDHJ2
1        CLM_HIPPS_TB                     Claim SNF & HHA Health Insurance      PPS Table
         ------------                     -------------------------------------------------

                                  HDHJ3
                                  HDHJ4
                                  HDHJ5
                                  HDHJ6
                                  HDHJ7
                                  HDHJ8
                                  **HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low**
                                  HDHK1
                                  HDHK2
                                  HDHK3
                                  HDHK4
                                  HDHK5
                                  HDHK6
                                  HDHK7
                                  HDHK8
```

```
                              **HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod**
                              HDHL1
                              HDHL2
                              HDHL3
                              HDHL4
                              HDHL5
                              HDHL6
                              HDHL7
                              HDHL8
                              **HHRG = C3F3S3/Clinical = High, Functional = High, Service = High**
                              HDHM1
                              HDHM2
                              HDHM3
                              HDHM4
                              HDHM5
                              HDHM6
                              HDHM7
                              HDHM8
                              **HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min**
                              HDIJ1
                              HDIJ2
                              HDIJ3
                              HDIJ4
                              HDIJ5
                              HDIJ6
                              HDIJ7
                              HDIJ8
                              **HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low**
                              HDIK1
                              HDIK2
                              HDIK3
                              HDIK4
                              HDIK5
                              HDIK6
                              HDIK7
                              HDIK8
                              **HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod**
                              HDIL1
                              HDIL2
                              HDIL3
                              HDIL4
                              HDIL5
                              HDIL6
1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance      PPS Table
         ------------                 -------------------------------------------------

                              HDIL7
                              HDIL8
                              **HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High**
                              HDIM1
                              HDIM2
                              HDIM3
                              HDIM4
                              HDIM5
                              HDIM6
                              HDIM7
                              HDIM8
```

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1    CLM_IP_ADMSN_TYPE_TB                    Claim Inpatient Admission Type Table
     --------------------                    ------------------------------------


                          0 = Blank
                          1 = Emergency - The patient required
                              immediate medical intervention as a
                              result of severe, life threatening, or
                              potentially disabling conditions.
                              Generally, the patient was admitted
                              through the emergency room.
                          2 = Urgent - The patient required immediate
                              attention for the care and treatment
                              of a physical or mental disorder.
                              Generally, the patient was admitted to
                              the first available and suitable
                              accommodation.
                          3 = Elective - The patient's condition
                              permitted adequate time to schedule the
                              availability of suitable accommodations.
                          4 = Newborn - Necessitates the use of
                              special source of admission codes.

                          5 THRU 8 =  Reserved.
                          9 =  Unknown - Information not available.


1    CLM_MDCR_NPMT_RSN_TB                    Claim Medicare Non-Payment Reason Table
     --------------------                    ---------------------------------------


                          A = Covered worker's compensation (Obsolete)
                          B = Benefit exhausted
                          C = Custodial care - noncovered care
                              (includes all 'beneficiary at fault'
                              waiver cases) (Obsolete)
                          E = HMO out-of-plan services not emergency
                              or urgently needed (Obsolete)
                          E = MSP cost avoided - IRS/SSA/HCFA Data
                              Match (eff. 7/00)
                          F = MSP cost avoid HMO Rate Cell (eff. 7/00)
                          G = MSP cost avoided Litigation Settlement
                              (eff. 7/00)
                          H = MSP cost avoided Employer Voluntary
                              Reporting (eff. 7/00)
                          J = MSP cost avoid Insurer Voluntary
                              Reporting (eff. 7/00)
                          K = MSP cost avoid Initial Enrollment
                              Questionnaire (eff. 7/00)
                          N = All other reasons for nonpayment
                          P = Payment requested
                          Q = MSP cost avoided Voluntary Agreement
                              (eff. 7/00)
                          R = Benefits refused, or evidence not
                              submitted
                          T = MSP cost avoided - IEQ contractor
                              (eff. 9/76) (obsolete 6/30/00)
                          U = MSP cost avoided - HMO rate cell
                              adjustment (eff. 9/76) (Obsolete 6/30/00)
```

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                 V = MSP cost avoided - litigation
                     settlement (eff. 9/76) (Obsolete 6/30/00)
                 W = Worker's compensation (Obsolete)
                 X = MSP cost avoided - generic
                 Y = MSP cost avoided - IRS/SSA data
                     match project (obsolete 6/30/00)
                 Z = Zero reimbursement RAPs -- zero reimbursement
                     made due to medical review intervention or
                     where provider specific zero payment has been
                     determined. (effective with HHPPS - 10/00)

1      CLM_OCRNC_SPAN_TB                        Claim Occurrence Span Table
       -----------------                        ---------------------------


                 70 = Eff 10/93, payer use only, the
                      nonutilization from/thru dates
                      for PPS-inlier stay where bene had
                      exhausted all full/coinsurance days, but
                      covered on cost report.
                      SNF qualifying hospital stay from/thru dates
                 71 = Hospital prior stay dates - the from/
                      thru dates of any hospital stay that
                      ended within 60 days of this hospital
                      or SNF admission.
                 72 = First/last visit - the dates of the
                      first and last visits occurring in this
                      billing period if the dates are different
                      from those in the statement covers period.
                 73 = Benefit eligibility period - the
                      inclusive dates during which CHAMPUS
                      medical benefits are available to a
                      sponsor's bene as shown on the
                      bene's ID card.
                 74 = Non-covered level of care - The from/
                      thru dates of a period at a noncovered
                      level of care in an otherwise
                      covered stay, excluding any period
                      reported with occurrence span code 76,
                      77, or 79.
                 75 = The from/thru dates of SNF level of care
                      during IP hospital stay.  Shows PRO approval
                      of patient remaining in hospital
                      because SNF bed not available.
                      not applicable to swing bed
                      cases. PPS hospitals use in day
                      outlier cases only.
                 76 = Patient liability - From/thru
                      dates of period of noncovered care
                      for which hospital may charge
                      bene. The FI or PRO must have
                      approved such charges in advance.
                      patient must be notified in writing
                      3 days prior to noncovered period
                 77 = Provider liability - The from/thru
                      dates of period of noncovered care
                      for which the provider is liable.
                      Eff 3/92, applies to provider liability
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                               where bene is charged with utilization
                               and is liable for deductible/coinsurance
                    78 = SNF prior stay dates - The from/
                               thru dates of any SNF stay that
                               ended within 60 days of this hospital
                               or SNF admission.
                    79 = (Payer code) -
                               Eff 3/92, from/thru dates of
                               period of noncovered care where
                               bene is not charged with utilization,
                               deductible, or coinsurance.
                               and provider is liable.
                               Eff 9/93, noncovered period of care
                               due to lack of medical necessity.
1      CLM_OCRNC_SPAN_TB                      Claim Occurrence Span Table
       -----------------                      ---------------------------

                    80 - 99 = Reserved for state assignment
                    M0 = PRO/UR approved stay dates - Eff 10/93,
                               the first and last days that were
                               approved where not all of the stay was
                               approved.

1      CLM_PPS_IND_TB                          Claim PPS Indicator Table
       --------------                          -------------------------


                    ***Effective NCH weekly process date 10/3/97 - 5/29/98***

                    0 = not PPS bill (claim contains no PPS indicator)
                    2 = PPS bill ( claim contains PPS indicator)

                    ***Effective NCH weekly process date 6/5/98***

                    0 = not applicable (claim contains neither PPS
                        nor deemed insured MQGE status indicators)
                    1 = Deemed insured MQGE (claim contains deemed
                        insured MQGE indicator but not PPS indicator)
                    2 = PPS bill ( claim contains PPS indicator but no
                        deemed insured MQGE status indicator)
                    3 = Both PPS and deemed insured MQGE (contains both
                        PPS and deemed insured MQGE indicators)

1      CLM_RLT_COND_TB                         Claim Related Condition Table
       ---------------                         -----------------------------


                    01 = Military service related - Medical
                         condition incurred during military
                         service.
                    02 = Employment related - Patient alleged
                         that the medical condition causing this
                         episode of care was due to environment/
                         events resulting from employment.
                    03 = Patient covered by insurance not
                         reflected here - Indicates that patient
                         or patient representative has stated
                         that coverage may exist beyond that
```

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                  reflected on this bill.
          04 = Health Maintenance Organization (HMO)
                  enrollee - Medicare beneficiary is
                  enrolled in an HMO.  Eff 9/93, hospital
                  must also expect to receive payment
                  from HMO.
          05 = Lien has been filed - Provider has
                  filed legal claim for recovery of funds
                  potentially due a patient as a result
                  of legal action initiated by or on
                  behalf of the patient.
          06 = ESRD patient in 1st 18 months of entitlement
                  covered by employer group health insurance -
                  indicates Medicare may be secondary
                  insurer.  Eff 3/1/96, ESRD patient in 1st
                  30 months of entitlement covered by employer
                  group health insurance.
          07 = Treatment of nonterminal condition for
                  hospice patient - The patient is a
                  hospice enrollee, but the provider is
                  not treating a terminal condition and
                  is requesting Medicare reimbursement.
          08 = Beneficiary would not provide information
                  concerning other insurance coverage.
          09 = Neither patient nor spouse is employed
                  - Code indicates that in response to
                  development questions, the patient and
                  spouse have denied employment.
          10 = Patient and/or spouse is employed but
                  no EGHP coverage exists or (eff 9/93)
                  other employer sponsored/provided
                  health insurance covering patient.
          11 = The disabled beneficiary and/or family
                  member has no group coverage from a LGHP
                  or (eff 9/93) other employer
                  sponsored/provided health insurance
                  covering patient.
          12 = Payer code - Reserved for internal
                  use only by third party payers.  HCFA
                  will assign as needed.  Providers will
                  not report them.
          13 = Payer code - Reserved for internal
                  use only by third party payers.  HCFA
                  will assign as needed.  Providers will
                  not report them.
          14 = Payer code - Reserved for internal
```

1   CLM_RLT_COND_TB   Claim Related Condition Table
        ---------------   -----------------------------

```
                  use only by third party payers.  HCFA
                  will assign as needed.  Providers will
                  not report them.
          15 = Clean claim (eff 10/92)
          16 = SNF transition exemption - An
                  exemption from the post-hospital
                  requirement applies for this SNF stay
                  or the qualifying stay dates are more
                  than 30 days prior to the admission date
```

```
17 = Patient is over 100 years old - Code
     indicates that the patient was over
     100 years old at the date of admission.
18 = Maiden name retained - A dependent
     spouse entitled to benefits who does
     not use her husband's last name.
19 = Child retains mother's name - A
     patient who is a dependent child
     entitled to CHAMPVA benefits that does
     not have father's last name.
20 = Bene requested billing - Provider
     realizes the services on this bill are at a
     noncovered level of care or otherwise excluded
     from coverage, but the bene has requested
     formal determination
21 = Billing for denial notice - The SNF or HHA
     realizes services are at a noncovered level of
     care or excluded, but requests a Medicare denial
     in order to bill medicaid or other insurer
22 = Patient on multiple drug regimen - A
     patient who is receiving multiple
     intravenous drugs while on home IV
     therapy
23 = Homecaregiver available - The patient
     has a caregiver available to assist him
     or her during self-administration of an
     intravenous drug
24 = Home IV patient also receiving HHA
     services - the patient is under care
     of HHA while receiving home IV drug
     therapy services
25 = Reserved for national assignment
26 = VA eligible patient chooses to
     receive services in Medicare certified
     facility rather than a VA facility
     (eff 3/92)
27 = Patient referred to a sole community
     hospital for a diagnostic laboratory
     test - (sole community hospital only).
     (eff 9/93)
28 = Patient and/or spouse's EGHP is
     secondary to Medicare -
     Qualifying EGHP for employers who have
     fewer than 20 employees. (eff 9/93)
29 = Disabled beneficiary and/or family
     member's LGHP is secondary to
     Medicare - Qualifying LGHP for
     employer having fewer than 100 full and
     part-time employees
```

```
31 = Patient is student (full time - day) -
     Patient declares that he or she is
     enrolled as a full time day student.
32 = Patient is student (cooperative/work
     study program)
33 = Patient is student (full time - night)
```

```
                     - Patient declares that he or she is
                       enrolled as a full time night student.
              34 = Patient is student (part time) -
                       Patient declares that he or she is
                       enrolled as a part time student.
              36 = General care patient in a special
                       unit - Patient is temporarily placed in
                       special care unit bed because no
                       general care beds were available.
              37 = Ward accommodation is patient's
                       request - Patient is assigned to ward
                       accommodations at patient's request.
              38 = Semi-private room not available -
                       Indicates that either private or ward
                       accommodations were assigned because
                       semi-private accomodations were not
                       available.
              39 = Private room medically necessary -
                       Patient needed a private room for
                       medical reasons.
              40 = Same day transfer - Patient
                       transferred to another facility
                       before midnight of the day of admission.
              41 = Partial hospitalization - Eff 3/92,
                       indicates claim is for partial
                       hospitalization services.  For OP
                       services, this includes a variety
                       of psych programs.
              42 = Reserved for national assignment.
              43 = Reserved for national assignment.
              44 = Reserved for national assignment.
              45 = Reserved for national assignment.
              46 = Nonavailability statement on file for
                       CHAMPUS claim for nonemergency IP care
                       for CHAMPUS bene residing within the
                       catchment area (usually a 40 mile
                       radius) of a uniform services hospital.
              47 = Reserved for CHAMPUS.
              48 = Reserved for national assignment.
              49 = Reserved for national assignment.
              50 = Reserved for national assignment.
              51 = Reserved for national assignment.
              52 = Reserved for national assignment.
              53 = Reserved for national assignment.
              54 = Reserved for national assignment.
              55 = SNF bed not available - The patient's
                       SNF admission was delayed more than 30
                       days after hospital discharge because
                       a SNF bed was not available.
              56 = Medical appropriateness - Patient's
                       SNF admission was delayed more than 30
                       days after hospital discharge because
```

```
1     CLM_RLT_COND_TB                        Claim Related Condition Table
      ---------------                        ----------------------------
```

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                       physical condition made it inappropriate
                       to begin active care within that period
              57 = SNF readmission - Patient previously
```

```
                 received Medicare covered SNF care
                 within 30 days of the current SNF
                 admission.
          58 = Payment of SNF claims for beneficiaries
                 disenrolling from terminating M+C plans
                 plans who have not met the 3-day hospital
                 stay requirement (eff. 10/1/00)
          59 = Reserved for national assignment.
          60 = Operating cost day outlier - PRICER
                 indicates this bill is length of stay
                 outlier (PPS)
          61 = Operating cost cost outlier - PRICER
                 indicates this bill is a cost outlier
                 (PPS)
          62 = PIP bill - This bill is a periodic
                 interim payment bill.
          63 = PRO denial received before batch
                 clearance report - The HCSSACL receipt date
                 is used on PRO adjustment if the PRO's
                 notification is before orig bill's acceptance
                 report. (Payer only code eff 9/93)
          64 = Other than clean claim - The claim is
                 not a 'clean claim'
          65 = Non-PPS code - The bill is not a
                 prospective payment system bill.
          66 = Outlier not claimed - Bill may meet
                 the criteria for cost outlier, but the
                 hospital did not claim the cost outlier
                 (PPS)
          67 = Beneficiary elects not to use LTR days
          68 = Beneficiary elects to use LTR days
          69 = Operating IME Payment Only - providers
                 request for IME payment for each discharge
                 of MCO enrollee, beginning 1/1/98, from
                 teaching hospitals (facilities with approved
                 medical residency training program); not
                 stored in NCH.  Exception:  problem in
                 startup year may have resulted in this
                 special IME payment request being erroneously
                 stored in NCH.  If present, disregard claim
                 as condition code '69' is not valid NCH
                 claim.
          70 = Self-administered EPO - Billing is
                 for a home dialysis patient who self
                 administers EPO.
          71 = Full care in unit - Billing is for a
                 patient who received staff assisted
                 dialysis services in a hospital or
                 renal dialysis facility.
          72 = Self care in unit - Billing is for a
                 patient who managed his own dialysis
                 services without staff assistance in a
                 hospital or renal dialysis facility.
          73 = Self care training - Billing is for
                 special dialysis services where the
```

```
            patient and helper (if necessary) were
            learning to perform dialysis.
     74 = Home - Billing is for a patient who
            received dialysis services at home.
     75 = Home 100% reimbursement -
            (not to be used for services after 4/15/90)
            The billing is for home dialsis patient using
            a dialysis machine that was purchased
            under the 100% program.
     76 = Back-up facility - Billing is for a
            patient who received dialysis services
            in a back-up facility.
     77 = Provider accepts or is obligated/
            required due to contractual agreement
            or law to accept payment by a primary
            payer as payment in full - Medicare
            pays nothing.
     78 = New coverage not implemented by HMO -
            eff 3/92, indicates newly covered
            service under Medicare for which HMO
            does not pay.
     79 = CORF services provided off site -
            Code indicates that physical therapy,
            occupational therapy, or speech path-
            ology services were provided off site.
     80 - 99 = Reserved for state assignment.
     A0 = CHAMPUS external partnership program
            special program indicator code. (eff 10/93)
     A1 = EPSDT/CHAP - Early and periodic
            screening diagnosis and treatment
            special program indicator code. (eff 10/93)
     A2 = Physically handicapped children's
            program - Services provided receive
            special funding through Title 8 of
            the Social Security Act or the CHAMPUS
            program for the handicapped. (eff 10/93)
     A3 = Special federal funding - Designed for
            uniform use by state uniform billing
            committees.
            Special program indicator code (eff 10/93)
     A4 = Family planning - Designed for
            uniform use by state uniform billing
            committees.
            Special program indicator code (eff 10/93)
     A5 = Disability - Designed for uniform
            use by state uniform billing
            committees.
            Special program indicator code (eff 10/93)
     A6 = PPV/Medicare - Identifies that
            pneumococcal pneumonia 100% payment
            vaccine (PPV) services should be
            reimbursed under a special Medicare
            program provision.
            Special program indicator code (eff 10/93)
     A7 = Induced abortion to avoid danger to
            woman's life.
            Special program indicator code (eff 10/93)
     A8 = Induced abortion - Victim of rape/
```

                    incest.
                    Special program indicator code (eff 10/93)
          A9 = Second opinion surgery - Services
                    requested to support second opinion
                    on surgery. Part B deductible and
                    coinsurance do not apply.
                    Special program indicator code (eff 10/93)
          B0 = Special program indicator
                    Reserved for national assignment.
          B1 = Special program indicator
                    Reserved for national assignment.
          B2 = Special program indicator
                    Reserved for national assignment.
          B3 = Special program indicator
                    Reserved for national assignment.
          B4 = Special program indicator
                    Reserved for national assignment.
          B5 = Special program indicator
                    Reserved for national assignment.
          B6 = Special program indicator
                    Reserved for national assignment.
          B7 = Special program indicator
                    Reserved for national assignment.
          B8 = Special program indicator
                    Reserved for national assignment.
          B9 = Special program indicator
                    Reserved for national assignment.
          C0 = Reserved for national assignment.
          C1 = Approved as billed - The services
                    provided for this billing period have
                    been reviewed by the PRO/UR or
                    intermediary and are fully approved
                    including any day or cost outlier. (eff 10/93)
          C2 = Automatic approval as billed based on
                    focused review. (No longer used for
                    Medicare)
                    PRO approval indicator services (eff 10/93)
          C3 = Partial approval - The services
                    provided for this billing period have
                    been reviewed by the PRO/UR or
                    intermediary and some portion has been
                    denied (days or services). (eff 10/93)
          C4 = Admission/services denied - Indicates
                    that all of the services were denied
                    by the PRO/UR.
                    PRO approval indicator services (eff 10/93)
          C5 = Postpayment review applicable - PRO/UR
                    review to take place after payment.
                    PRO approval indicator services (eff 10/93)
          C6 = Admission preauthorization - The
                    PRO/UR authorized this admission/
                    service but has not reviewed the
                    services provided.
                    PRO approval indicator services (eff 10/93)
          C7 = Extended authorization - the PRO has

```
                                      authorized these services for an
                                      extended length of time but has not
                                      reviewed the services provided.
    1      CLM_RLT_COND_TB                        Claim Related Condition Table
           ---------------                        ----------------------------

                                      PRO approval indicator services (eff 10/93)
                           C8 = Reserved for national assignment.
                                      PRO approval indicator services (eff 10/93)
                           C9 = Reserved for national assignment.
                                      PRO approval indicator services (eff 10/93)
                           D0 = Changes to service dates.
                                Change condition (eff 10/93)
                           D1 = Changes in charges.
                                Change condition (eff 10/93)
                           D2 = Changes in revenue codes/HCPCS.
                                Change condition (eff 10/93)
                           D3 = Second or subsequent interim
                                PPS bill.
                                Change condition (eff 10/93)
                           D4 = Change in grouper input (diagnosis
                                and/or procedures are changed resulting
                                in a different DRG).
                                Change condition (eff 10/93)
                           D5 = Cancel only to correct a beneficiary
                                claim account number or provider
                                identification number.
                                change condition (eff 10/93)
                           D6 = Cancel only to repay a duplicate
                                payment or OIG overpayment (includes
                                cancellation of an OP bill containing
                                services required to be included on the
                                IP bill). Change condition eff 10/93.
                           D7 = Change to make Medicare the secondary
                                payer.
                                Change condition (eff 10/93)
                           D8 = Change to make Medicare the primary
                                payer.
                                Change condition (eff 10/93)
                           D9 = Any other change.
                                Change condition (eff 10/93)
                           E0 = Change in patient status.
                                Change condition (eff 10/93)
                           EY = National Emphysema Treatment Trial (NETT)
                                or Lung Volume Reduction Surgery (LVRS)
                                clinical study (eff. 11/97)
                           G0 = Multiple medical visits occur on the same
                                day in the same revenue center but visits
                                are distinct and constitute independent
                                visits (allows for payment under outpatient
                                PPS -- eff. 7/3/00).
                           M0 = All inclusive rate for outpatient services.
                                (payer only code)
                           M1 = Roster billed influenza virus vaccine.
                                (payer only code)
                                Eff 10/96, also includes pneumoccocal
                                pneumonia vaccine (PPV)
                           M2 = HH override code - home health total
```

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                               reimbursement exceeds the $150,000 cap
                               or the number of total visits exceeds the
                               150 limitation. (eff 4/3/95)
                               (payer only code)
                          W0 = United Mine Workers of America (UMWA)
                               SNF demonstration indicator (eff 1/97);
1      CLM_RLT_COND_TB                    Claim Related Condition Table
       ---------------                    ----------------------------

                               but no claims transmitted until 2/98)


1      CLM_RLT_OCRNC_TB                   Claim Related Occurrence Table
       ----------------                   -----------------------------


                          01 = Auto accident - The date of an auto
                               accident.
                          02 = No-fault insurance involved, including
                               auto accident/other - The date of an
                               accident where the state has applicable
                               no-fault liability laws, (i.e., legal
                               basis for settlement without admission
                               or proof of guilt).
                          03 = Accident/tort liability - The date of
                               an accident resulting from a third
                               party's action that may involve a civil
                               court process in an attempt to require
                               payment by the third party, other than
                               no-fault liability.
                          04 = Accident/employment related - The
                               date of an accident relating to the
                               patient's employment.
                          05 = Other accident - The date of an accident
                               not described by the codes 01 thru 04.
                          06 = Crime victim - Code indicating the
                               date on which a medical condition
                               resulted from alleged criminal action
                               committed by one or more parties.
                          07 = Reserved for national assignment.
                          08 = Reserved for national assignment.
                          11 = Onset of symptoms/illness - The date
                               the patient first became aware of
                               symptoms/illness.
                          12 = Date of onset for a chronically
                               dependent individual - Code indicates
                               the date the patient/bene became
                               a chronically dependent individual.
                          13 = Reserved for national assignment.
                          14 = Reserved for national assignment.
                          15 = Reserved for national assignment.
                          16 = Reserved for national assignment.
                          17 = Date outpatient occupational therapy
                               plan established or last reviewed -
                               Code indicating the date an occupational
                               therapy plan was established or
                               last reviewed (eff 3/93)
                          18 = Date of retirement (patient/bene)
                               - Code indicates the date of retirement
```

```
                         for the patient/bene.
             19 = Date of retirement spouse -
                  Code indicates the date of retirement
                  for the patient's spouse.
             20 = Guarantee of payment began - The date
                  on which the provider began claiming
                  Medicare payment under the guarantee
                  of payment provision.
             21 = UR notice received - Code indicating
                  the date of receipt by the hospital
                  of the UR committee's finding that the
                  admission or future stay was not
                  medically necessary.
             22 = Active care ended - The date on which
1       CLM_RLT_OCRNC_TB                    Claim Related Occurrence Table
        ----------------                    -----------------------------

                  a covered level of care ended in a SNF
                  or general hospital, or date active care
                  ended in a psychiatric or tuberculosis
                  hospital.  (For use by intermediary only)
             23 = Reserved for national assignment
                  (eff 10/93).
                  Benefits exhausted - The last date
                  for which benefits can be paid.
                  (term 9/30/93; replaced by code A3)
             24 = Date insurance denied - The date the
                  insurer's denial of coverage was
                  received by a higher priority payer.
             25 = Date benefits terminated by primary
                  payer - The date on which coverage
                  (including worker's compensation benefits
                  or no-fault coverage) is no longer
                  available to the patient.
             26 = Date skilled nursing facility (SNF)
                  bed available - The date on which a SNF
                  bed became available to a hospital
                  inpatient who required only SNF level of
                  care.
             27 = Date home health plan established or
                  last reviewed - Code indicating the
                  date a home health plan of treatment
                  was established or last reviewed.
                  not used by hospital unless owner of facility
             28 = Date comprehensive outpatient rehabi-
                  litation plan established or last re-
                  viewed - Code indicating the date a
                  comprehensive outpatient rehabilitation
                  plan was established or last reviewed.
                  not used by hospital unless owner of facility
             29 = Date OPT plan established or last
                  reviewed - the date a plan of treatment
                  was established for outpatient physical
                  therapy.
                  Not used by hospital unless owner of facility
             30 = Date speech pathology plan treatment
                  established or last reviewed - The date
                  a speech pathology plan of treatment
```

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                  was established or last reviewed.
                  Not used by hospital unless owner of facility
             31 = Date bene notified of intent
                  to bill (accommodations) - The date of
                  the notice provided to the patient by
                  the hospital stating that he no longer
                  required a covered level of IP care.
             32 = Date bene notified of intent
                  to bill (procedures or treatment) - The
                  date of the notice provided to the patient
                  by the hospital stating requested care
                  (diagnostic procedures or treatments) is
                  not considered reasonable or necessary.
             33 = First day of the Medicare coordination
                  period for ESRD bene - During
                  which Medicare benefits are secondary
                  to benefits payable under an EGHP.
1      CLM_RLT_OCRNC_TB                    Claim Related Occurrence Table
       ----------------                    -----------------------------

                  Required only for ESRD beneficiaries.
             34 = Date of election of extended care
                  facilities - The date the guest elected
                  to receive extended care services (used
                  by Christian Science Sanatoria only).
             35 = Date treatment started for physical
                  therapy - Code indicates the date
                  services were initiated by the billing
                  provider for physical therapy.
             36 = Date of discharge for the IP
                  hospital stay when patient
                  received a transplant procedure
                  - Hospital is billing for
                  immunosuppressive drugs.
             37 = The date of discharge
                  for the IP hospital stay when
                  patient received a noncovered
                  transplant procedure - Hospital
                  is billing for immunosuppresive drugs.
             38 = Date treatment started for home IV
                  therapy - Date the patient was first
                  treated in his home for IV therapy.
             39 = Date discharged on a continuous
                  course of IV therapy - Date the patient
                  was discharged from the hospital on a
                  continuous course of IV therapy.
             40 = Scheduled date of admission - The
                  date on which a patient will be admitted
                  as an inpatient to the hospital.
                  (This code may only be used on an
                  outpatient claim.)
             41 = The date on which the first
                  outpatient diagnostic test was
                  performed as part of a pre-admission
                  testing (PAT) program.  This code may
                  only be used if a date of admission
                  was scheduled prior to the administration
                  of the test(s).
```

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                         42 = Date of discharge/termination of hospice
                              care - for the final bill for hospice
                              care.  Eff 5/93, definition revised to
                              apply only to date patient revoked
                              hospice election.
                         43 = Reserved for national assignment.
                         44 = Date treatment started for occupational
                              therapy - Code indicates the date
                              services were initiated by the billing
                              provider for occupational therapy.
                         45 = Date treatment started for speech
                              therapy - Code indicates the date
                              services were initiated by the billing
                              provider for speech therapy.
                         46 = Date treatment started for cardiac
                              rehabilitation - Code indicates the
                              date services were initiated by the
                              billing provider for cardiac
                              rehabilitation.
                         47 = Noncovered Outlier Stay Began- code
1        CLM_RLT_OCRNC_TB                  Claim Related Occurrence Table
         ----------------                  -----------------------------

                              indicates the date that cost outlier
                              status began and no Medicare payment
                              will be made because all benefits have
                              been exhausted during the inlier stay or
                              the beneficiary does not elect to use life
                              time reserve days (to be implemented in
                              1999).
                         48 = Payer code - Code reserved for
                              internal use only by third party
                              payers.  HCFA assigns as needed for
                              your use.  Providers will not report it.
                         49 = Payer code - Code reserved for
                              internal use only by third party
                              payers.  HCFA assigns as needed for
                              your use.  Providers will not report it.
                    50 - 69 = Reserved for state assignment
                         A1 = Birthdate, Insured A - The birthdate of
                              the individual in whose name the insurance
                              is carried. (Eff 10/93)
                         A2 = Effective date, Insured A policy - A
                              code indicating the first date insurance
                              is in force. (eff 10/93)
                         A3 = Benefits exhausted - Code indicating
                              the last date for which benefits are
                              available and after which no payment
                              can be made to payer A.  (eff 10/93)
                         B1 = Birthdate, Insured B - The birthdate of
                              the individual in whose name the insurance
                              is carried. (eff 10/93)
                         B2 = Effective date, Insured B policy - A
                              code indicating the first date insurance
                              is in force. (eff 10/93)
                         B3 = Benefits exhausted - code indicating
                              the last date for which benefits are
                              available and after which no payment
```

```
                        can be made to payer B.  (eff 10/93)
          C1 = Birthdate, Insured C - The birthdate of
               the individual in whose name the insurance
               is carried. (eff 10/93)
          C2 = Effective date, Insured C policy - A
               code indicating the first date insurance
               is in force. (eff 10/93)
          C3 = Benefits exhausted - Code indicating
               the last date for which benefits are
               available and after which no payment
               can be made to payer C.  (eff 10/93)

 1    CLM_SRC_IP_ADMSN_TB                Claim Source Of Inpatient Admission Table
      -------------------                ----------------------------------------


                          **For Inpatient/SNF Claims:**


          0 = ANOMALY: invalid value, if present,
              translate to '9'
          1 = Physician referral - The patient was
              admitted upon the recommendation of
              a personal physician.
          2 = Clinic referral - The patient was
              admitted upon the recommendation of
              this facility's clinic physician.
          3 = HMO referral - The patient was admitted
              upon the recommendation of an health
              maintenance organization (HMO)
              physician.
          4 = Transfer from hospital - The patient
              was admitted as an inpatient transfer
              from an acute care facility.
          5 = Transfer from a skilled nursing
              facility (SNF) - The patient was
              admitted as an inpatient transfer
              from a SNF.
          6 = Transfer from another health care
              facility - The patient was admitted
              as a transfer from a health care
              facility other than an acute care
              facility or SNF.
          7 = Emergency room - The patient was
              admitted upon the recommendation of
              this facility's emergency room
              physician.
          8 = Court/law enforcement - The patient was
              admitted upon the direction of a
              court of law or upon the request of
              a law enforcement agency's
              representative.
          9 = Information not available -  The means
              by which the patient was admitted is
              not known.
          A = Transfer from a Critical Access Hospital -
              patient was admitted/referred to this
              facility as a transfer from a Critical
```

```
                            Access Hospital.
                    ----------------------------------------
                        **For Newborn Type of Admission**

                    1 = Normal delivery - A baby delivered with
                        out complications.
                    2 = Premature delivery - A baby delivered
                        with time and/or weight factors
                        qualifying it for premature status.
                    3 = Sick baby - A baby delivered with
                        medical complications, other than those
                        relating to premature status.
                    4 = Extramural birth - A baby delivered in
                        a nonsterile environment.
                    5-8 = Reserved for national assignment.
1    CLM_SRC_IP_ADMSN_TB                Claim Source Of Inpatient Admission Table
     -------------------                ----------------------------------------

                    9 = Information not available.

1    CLM_SRVC_CLSFCTN_TYPE_TB           Claim Service Classification Type Table
     -----------------------            ---------------------------------------


                      For facility type code 1 thru 6, and 9

                    1 = Inpatient (including Part A)
                    2 = Hospital based or Inpatient (Part B only)
                        or home health visits under Part B
                    3 = Outpatient (HHA-A also)
                    4 = Other (Part B)
                    5 = Intermediate care - level I
                    6 = Intermediate care - level II
                    7 = Subacute Inpatient
                        (formerly Intermediate care - level III)
                    8 = Swing beds (used to indicate billing for
                        SNF level of care in a hospital with an
                        approved swing bed agreement)
                    9 = Reserved for national assignment

                      For facility type code 7

                    1 = Rural health
                    2 = Hospital based or independent renal
                        dialysis facility
                    3 = Free-standing provider based federally
                        qualified health center (eff 10/91)
                    4 = Other Rehabilitation Facility (ORF) and
                        Community Mental Health Center (CMHC)
                        (eff 10/91 - 3/97); ORF only (eff. 4/97)
                    5 = Comprehensive Rehabilitation Center
                          (CORF)
                    6 = Community Mental Health Center (CMHC) (eff 4/97)
                    7-8 = Reserved for national assignment
                    9 = Other

                      For facility type code 8
```

```
                           1 = Hospice (non-hospital based)
                           2 = Hospice (hospital based)
                           3 = Ambulatory surgical center in hospital
                               outpatient department
                           4 = Freestanding birthing center
                           5 = Critical Access Hospital (eff. 10/99)
                               formerly Rural primary care hospital
                               (eff. 10/94)
                           6-8 = Reserved for national use
                           9 = Other

1       CLM_TRANS_TB                              Claim Transaction Table
        ------------                             -----------------------


                           0 = Religious NonMedical Health Care Institutions (RNHCI)
                               bill (prior to 8/00, Christian Science bill), SNF bill,
                               or state buy-in
                           1 = Psychiatric hospital facility bill or dummy psychiatric
                           2 = Tuberculosis hospital facility bill
                           3 = General care hospital facility bill or dummy LRD
                           4 = Regular SNF bill
                           5 = Home health agency bill (HHA)
                           6 = Outpatient hospital bill
                           C = CORF bill - type of OP bill in the HHA bill format
                               (obsoleted 7/98)
                           H = Hospice bill

1       CLM_VAL_TB                                Claim Value Table
        ----------                               -----------------


                           04 = Inpatient professional component
                                charges which are combined billed -
                                For use only by some all inclusive
                                rate hospitals. (Eff 9/93)
                           05 = Professional component included in
                                charges and also billed separately to
                                carrier - For use on Medicare and
                                Medicaid bills if the state requests
                                this information.
                           06 = Medicare blood deductible - Total
                                cash blood deductible (Part A blood
                                deductible).
                           07 = Medicare cash deductible (term 9/30/93)
                                reserved for national assignment.
                                (eff 10/93)
                           08 = Medicare Part A lifetime reserve amount
                                in first calendar year - Lifetime reserve
                                amount charged in the year of admission.
                                (not stored in NCH until 2/93)
                           09 = Medicare Part A coinsurance amount in
                                the first calendar year - Coinsurance
                                amount charged in the year of admission.
                                (not stored in NCH until 2/93)
                           10 = Medicare Part A lifetime reserve amount
                                in the second calendar year - Lifetime
                                reserve amount charged in the year of
```

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                          discharge where the bill spans two
                          calendar years.
                          (not stored in NCH until 2/93)
              11 = Medicare Part A coinsurance amount in
                          the second calendar year - Coinsurance
                          amount charged in the year of discharge
                          where the bill spans two calendar years
                          (not stored in NCH until 2/93)
              12 = Amount is that portion of
                          higher priority EGHP insurance payment
                          made on behalf of aged bene
                          provider applied to Medicare
                          covered services on this bill.
                          Six zeroes indicate provider
                          claimed conditional Medicare payment.
              13 = Amount is that portion of higher
                          priority EGHP insurance payment made on
                          behalf of ESRD bene provider
                          applied to Medicare covered services
                          on this bill. Six zeroes indicate
                          the provider claimed conditional
                          Medicare payment.
              14 = That portion of payment from higher
                          priority no fault auto/other
                          liability insurance made on behalf of bene
                          provider applied to Medicare covered
                          services on this bill. Six zeroes indicate
                          provider claimed conditional payment
              15 = That portion of a payment from a
                          higher priority WC plan made on behalf
                          of a bene that the provider applied to

1         CLM_VAL_TB                              Claim Value Table
          ----------                              -----------------

                          Medicare covered services on this bill. Six
                          zeroes indicate the provider claimed
                          conditional Medicare payment.
              16 = That portion of a payment from
                          higher priority PHS or other federal
                          agency made on behalf of a
                          bene the provider applied
                          to Medicare covered services on this
                          bill. Six zeroes indicate
                          provider claimed conditional Medicare
                          payment.
              17 = Operating Outlier amount - Providers do
                          not report this.  For payer internal use
                          only.  Indicates the amount of day or
                          cost outlier payment to be made.
                          (Do not include any PPS capital outlier
                          payment in this entry).
              18 = Operating Disproportionate share amount -
                          Providers do not report this.  For
                          payer internal use only.  Indicates the
                          disproportionate share amount applicable
                          to the bill.  Use the amount provided by
                          the disproportionate share field in PRICER.
                          (Do not include any PPS capital DSH adjust-
```

```
                         ment in this entry).
                    19 = Operating Indirect medical education amount -
                         Providers do not report this.  For
                         payer internal use only.  Indicates the
                         indirect medical education amount applicable
                         to the bill.  (Do not include PPS capital
                         IME adjustment in this entry).
                    20 = Total payment sent provider for capital
                         under PPS, including HSP, FSP, outlier,
                         old capital, DSH adjustment, IME
                         adjustment, and any exception amount.
                         (used 10/1/91 - 3/1/92 for provider
                         reporting.  Payer only code eff 9/93.)
                    21 = Catastrophic - Medicaid - Eligibility
                         requirements to be determined at state
                         level.  (Medicaid specific/deleted 9/93)
                    22 = Surplus - Medicaid - Eligibility
                         requirements to be determined at state
                         level. (Medicaid specific/deleted 9/93)
                    23 = Recurring monthly income - Medicaid -
                         Eligibility requirements to be
                         determined at state level. (Medicaid
                         specific/deleted 9/93)
                    24 = Medicaid rate code - Medicaid -
                         Eligibility requirements to be
                         determined at state level. (Medicaid
                         specific/deleted 9/93)
                    31 = Patient liability amount - Amount
                         shown is that which you or the PRO
                         approved to charge the bene for
                         noncovered accommodations, diagnostic
                         procedures or treatments.
                    37 = Pints of blood furnished - Total
                         number of pints of whole blood or units
1        CLM_VAL_TB                             Claim Value Table
         ----------                             -----------------

                         of packed red cells furnished to the
                         patient. (eff 10/93)
                    38 = Blood deductible pints - The number
                         of unreplaced pints of whole blood or
                         units of packed red cells furnished for
                         which the patient is responsible.
                         (eff 10/93)
                    39 = Pints of blood replaced - The total
                         number of pints of whole blood or units
                         of packed red cells furnished to the
                         patient that have been replaced by or
                         on behalf of the patient. (eff 10/93)
                    40 = New coverage not implemented by HMO -
                         amount shown is for inpatient charges
                         covered by HMO (eff 3/92).
                         (use this code when the bill includes
                         inpatient charges for newly covered
                         services which are not paid by HMO.)
                    41 = Amount is that portion of
                         a payment from higher priority BL
                         program made on behalf of
```

```
               bene the provider applied
               to Medicare covered services on this
               bill. Six zeroes indicate the
               provider claimed conditional Medicare
               payment.
          42 = Amount is that portion of a payment
               from higher priority VA made on behalf
               of bene the provider applied
               to Medicare covered services on this
               bill. Six zeroes indicate the
               provider claimed conditional Medicare
               payment.
          43 = Disabled bene under age 65 with
               LGHP - Amount is that portion of
               a payment from a higher priority LGHP
               made on behalf of a disabled Medicare
               bene the provider applied to
               Medicare covered services on this bill.
          44 = Amount provider agreed to accept from
               primary payer when amount less than charges
               but more than payment received -
               When a lesser amount is received and the
               received amount is less than charges, a
               Medicare secondary payment is due.
          46 = Number of grace days - Following the
               date of the PRO/UR determination, this
               is the number of days determined by the
               PRO/UR to be necessary to arrange for
               the patient's post-discharge care.
               (eff 10/93)
          47 = Any liability insurance - Amount
               is that portion from a higher priority
               liability insurance made on behalf of
               Medicare bene the provider
               is applying to Medicare covered
               services on this bill. (Eff 9/93)
          48 = Hemoglobin reading - The latest
```

1   CLM_VAL_TB   Claim Value Table
          ----------   -----------------

```
               hemoglobin reading taken during this
               billing cycle.
          49 = Latest hematocrit reading taken
               during billing cycle - Usually
               reported in two pos. (a percentage) to
               left of the dollar/cent delimiter.
               if provided with a
               a decimal, use the 3rd pos. to right
               of the delimiter for the third digit.
          50 = Physical therapy visits - Indicates
               the number of physical therapy
               visits from onset (at billing provider)
               through this billing period.
          51 = Occupational therapy visits - Indicates
               the number of occupational therapy
               visits from onset (at the billing
               provider) through this billing period.
          52 = Speech therapy visits - Indicates
```

```
                          the number of speech therapy
                          visits from onset (at billing provider)
                          through this billing period.
           53 = Cardiac rehabilitation - Indicates
                          the number of cardiac rehabilitation
                          visits from onset (at billing
                          provider) through this billing period.
           54 = Reserved for national assignment.
           55 = Reserved for national assignment.
           56 = Hours skilled nursing provided - The
                          number of hours skilled nursing
                          provided during the billing period.  Count
                          only hours spent in the home.
           57 = Home health visit hours - The number
                          of home health aide services provided
                          during the billing period.  Count only
                          the hours spent in the home.
           58 = Arterial blood gas - Arterial blood
                          gas value at beginning of each reporting
                          period for oxygen therapy. This
                          value or value 59 will be required on
                          the initial bill for oxygen therapy and
                          on the fourth month's bill.
           59 = Oxygen saturation - Oxygen saturation
                          at the beginning of each reporting
                          period for oxygen therapy.  This value or
                          value 58 will be required on the
                          initial bill for oxygen therapy and on
                          the fourth month's bill.
           60 = HHA branch MSA - MSA in which HHA
                          branch is located.
           61 = Location of HHA service or hospice
                          service - the balanced budget act
                          (BBA) requires that the geographic
                          location of where the service was
                          provided be furnished instead of the
                          geographic location of the provider.
                          (eff. 10/1/97)
           62 = Number of Part A home health visits
                          accrued during a period of continuous
```

```
1        CLM_VAL_TB                                      Claim Value Table
         ----------                                      -----------------
```

```
                          care - necessitated by the change in
                          payment basis under HH PPS (eff. 10/00)
           63 = Number of Part B home health visits
                          accrued during a period of continuous
                          care - necessitated by the change in
                          payment basis under HH PPS (eff. 10/00)
           64 = Amount of home health payments attributed
                          to the Part A trust fund in a period
                          of continuous care - necessitated by the
                          change in payment basis under HH PPS
                          (eff. 10/00)
           65 = Amount of home health payments attributed
                          to the Part B trust fund in a period
                          of continuous care - necessitated by the
                          change in payment basis under HH PPS
```

```
              (eff. 10/00)
       66 = Reserved for national assignment.
       67 = Peritoneal dialysis - The number of
            hours of peritoneal dialysis provided
            during the billing period (only the
            hours spent in the home).
            (eff. 10/97)
       68 = EPO drug - Number of units of EPO
            administered relating to the billing
            period.
       69 = Reserved for national assignment
       70 = Interest amount - (Providers do not
            report this.)  Report the amount
            applied to this bill.
       71 = Funding of ESRD networks - (Providers
            do not report this.)  Report the
            amount the Medicare payment was
            reduced to help fund the ESRD networks.
       72 = Flat rate surgery charge - Code
            indicates the amount of the charge for
            outpatient surgery where the hospital
            has such a charging structure.
       73 = Drug deductible - (For internal use by
            third party payers only).  Report the
            amount of the drug deductible to be
            applied to the claim.
       74 = Drug coinsurance - (For internal use
            by third party payers only).  Report
            the amount of drug coinsurance to be
            applied to the claim.
       75 = Gramm/Rudman/Hollings - (Providers do
            not report this.)  Report the amount of
            the sequestration applied to this bill.
       76 = Report provider's percentage of
            billed charges interim rate during
            billing period.  Applies to OP
            hospital, SNF and HHA claims
            where interim rate is applicable.
            Report to left of dollar/cents delimiter.
            (TP payers internal use only)
       77 = Payer code - This codes is set
            aside for payer use only.  Providers
            do not report these codes.
```

1   CLM_VAL_TB   Claim Value Table
        ----------   -----------------

```
       78 = Payer code - This codes is set
            aside for payer use only.  Providers
            do not report these codes.
       79 = Payer code - This code is set
            aside for payer use only.  Providers
            do not report these codes.
       80 - 99 = Reserved for state assignment.
       A1 = Deductible Payer A - The amount
            assumed by the provider to be applied
            to the patient's deductible amount
            involving the indicated payer. (eff 10/93)
            - Prior value 07
```

```
          A2 = Coinsurance Payer A - The amount assumed
               by the provider to be applied to the
               patient's Part B coinsurance amount
               involving the indicated payer. (eff 10/93)
          A4 = Self-administered drugs administered in an
               emergency situation - Ordinarily the only
               noncovered self-administered drug
               paid for under Medicare in an emergency
               situation is insulin administered to a
               patient in a diabetic coma. (eff 7/97)
          B1 = Deductible Payer B - The amount
               assumed by the provider to be applied
               to the patient's deductible amount
               involving the indicated payer. (eff 10/93)
               - Prior value 07
          B2 = Coinsurance Payer B - the amount assumed
               by the provider to be applied to the
               patient's Part B coinsurance amount
               involving the indicated payer. (eff 10/93)
          C1 = Deductible Payer C - The amount
               assumed by the provider to be applied
               to the patient's deductible amount
               involving the indicated payer. (eff 10/93)
               - Prior value 07
          C2 = Coinsurance Payer C - The amount assumed
               by the provider to be applied to the
               patient's Part B coinsurance amount
               involving the indicated payer. (eff 10/93)
          Y1 = Part A demo payment - Portion of the
               payment designated as reimbursement for
               Part A services per the ORD contract.  No
               deductible or coinsurance has been
               applied.  (eff. 5/97)
          Y2 = Part B demo payment - Portion of the
               payment designated as reimbursement for
               Part B services for the ORD contract.
               No deductible or coinsurance has been
               applied.  (eff. 5/97)
          Y3 = Part B coinsurance - Amount of Part B
               coinsurance applied by the intermediary
               to this demo claim.   (eff. 5/97)
          Y4 = Conventional provider Part A payment -
               Amount Medicare would have reimbursed
               the provider for Part A services if
               there had been no demo.  (eff. 5/97)


  1  CTGRY_EQTBL_BENE_IDENT_TB          Category Equatable Beneficiary Identification Code (BIC) Table
     ------------------------           -------------------------------------------------------------


          NCH BIC              SSA Categories
          -------              --------------

          A  = A;J1;J2;J3;J4;M;M1;T;TA
          B  = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
               TB(F);TD(F);TE(F);TW(F)
          B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
               TD(M);TE(M);TW(M)
```

```
B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
     W7;TG(F);TL(F);TR(F);TX(F)
B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
     TL(M);TR(M);TX(M)
B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
     W8;TH(F);TM(F);TS(F);TY(F)
BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
     WC;TJ(F);TN(F);TT(F);TZ(F)
BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
     WJ;TK(F);TP(F);TU(F);TV(F)
BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
     TY(M)
BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
     TZ(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
     TV(M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
        equatable to F3)
CA-CZ = Equatable only to itself.  (e.g., CA is
        only equatable to CA)


        ---------------------------------------
                    RRB Categories

10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
84 = 84;86
85 = 85
```

```
1 DMERC_LINE_SCRN_RSLT_IND_TB              DMERC Line Screen Result Indicator Table
  ---------------------------              ----------------------------------------


        A = Denied for lack of medical necessity;
            highest level of review was automated
            level I review
        B = Reduced (partially denied) for lack
            of medical necessity; highest level
            of review was automated level I review
```

```
          C = Denied as statutorily noncovered;
              highest level of review was automated
              level I review
          D = Reserved for future use
          E = Paid after automated level I review
          F = Denied for lack of medical necessity;
              highest level of review was manual
              level I review
          G = Reduced (partially denied) for lack
              of medical necessity; highest level
              of review was manual level I review
          H = Denied as statutorily noncovered;
              highest level of review was manual
              level I review
          I = Denied for coding/unbundling reasons;
              highest level of review was manual
              level I review
          J = Paid after manual level I review
          K = Denied for lack of medical necessity;
              highest level of review was manual
              level II review
          L = Reduced (partially denied) for lack
              of medical necessity; highest level
              of review was manual level II review
          M = Denied as statutorily noncovered;
              highest level of review was manual
              level II review
          N = Denied for coding/unbundling reasons;
              highest level of review was manual
              level II review
          O = Paid after manual level II review
          P = Denied for lack of medical necessity;
              highest level of review was manual
              level III review
          Q = Reduced (partially denied) for lack
              of medical necessity; highest level
              of review was manual level III review
          R = Denied as statutorily noncovered;
              highest level of review was manual
              level III review
          S = Denied for coding/unbundling reasons;
              highest level of review was manual
              level III review
          T = Paid after manual level III review
```

```
  1   DMERC_LINE_SUPLR_TYPE_TB                DMERC Line Supplier Type Table
      ------------------------                ------------------------------


          0 = Clinics, groups, associations,
              partnerships, or other entities
              for whom the carrier's own ID number
              has been assigned.
          1 = Physicians or suppliers billing as
              solo practitioners for whom SSN's are
              shown in the physician ID code field.
          2 = Physicians or suppliers billing as
              solo practitioners for whom the carrier's
```

```
                          own physician ID code is shown.
                      3 = Suppliers (other than sole proprietorship)
                          for whom EI numbers are used in coding the
                          ID field.
                      4 = Suppliers (other than sole proprietorship)
                          for whom the carrier's own code has been
                          shown.
                      5 = Institutional providers and
                          independent laboratories for whom EI
                          numbers are used in coding the ID field.
                      6 = Institutional providers and
                          independent laboratories for whom the
                          carrier's own ID number is shown.
                      7 = Clinics, groups, associations, or
                          partnerships for whom EI numbers
                          are used in coding the ID field.
                      8 = Other entities for whom EI numbers
                          are used in coding the ID field or
                          proprietorship for whom EI numbers are
                          used in coding the ID field.

1    DRG_OUTLIER_STAY_TB             Diagnosis Related Group Outlier Patient Stay Table
     -------------------             --------------------------------------------------


                      0 = No outlier
                      1 = Day outlier (condition code 60)
                      2 = Cost outlier, (condition code 61)

                          *** Non-PPS Only ***

                      6 = Valid diagnosis related groups (DRG)
                          received from the intermediary
                      7 = HCFA developed DRG
                      8 = HCFA developed DRG using patient status
                          code
                      9 = Not groupable

1    FI_CLM_ACTN_TB                  Fiscal Intermediary Claim Action Table
     --------------                  --------------------------------------


                      1 = Original debit action (includes non-
                          adjustment RTI correction items) - it
                          will always be a 1 in regular bills.
                      2 = Cancel by credit adjustment - used
                          only in credit/debit pairs (under HHPPS,
                          updates the RAP).
                      3 = Secondary debit adjustment - used only
                          in credit/debit pairs (under HHPPS, would
                          be the final claim or an adjustment on
                          a LUPA).
                      4 = Cancel only adjustment (under HHPPS,
                          RAP/final claim/LUPA).
                      5 = Force action code 3
                      6 = Force action code 2
                      8 = Benefits refused (for inpatient bills,
                          an 'R' nonpayment code must also be
```

```
                        present
                9 = Payment requested (used on bills that
                    replace previously-submitted benefits-
                    refused bills, action code 8.  In such
                    cases a debit/credit pair is not re-
                    quired.  For inpatient bills, a 'P'
                    should be entered in the nonpayment
                    code.)

1        FI_NUM_TB                      Fiscal Intermediary Number Table
         ---------                      -------------------------------


                  00010 = Alabama BC
                  00020 = Arkansas BC
                  00030 = Arizona BC
                  00040 = California BC (term. 12/00)
                  00050 = New Mexico BC/CO
                  00060 = Connecticut BC
                  00070 = Delaware BC - terminated 2/98
                  00080 = Florida BC
                  00090 = Florida BC
                  00101 = Georgia BC
                  00121 = Illinois - HCSC
                  00123 = Michigan - HCSC
                  00130 = Indiana BC/Administar Federal
                  00131 = Illinois - Administar
                  00140 = Iowa - Wellmark (term. 6/2000)
                  00150 = Kansas BC
                  00160 = Kentucky/Administar
                  00180 = Maine BC
                  00181 = Maine BC - Massachusetts
                  00190 = Maryland BC
                  00200 = Massachusetts BC - terminated 7/97
                  00210 = Michigan BC - terminated 9/94
                  00220 = Minnesota BC
                  00230 = Mississippi BC
                  00231 = Mississippi BC/LA
                  00232 = Mississippi BC
                  00241 = Missouri BC - terminated 9/92
                  00250 = Montana BC
                  00260 = Nebraska BC
                  00270 = New Hampshire/VT BC
                  00280 = New Jersey BC (term. 8/2000)
                  00290 = New Mexico BC - terminated 11/95
                  00308 = Empire BC
                  00310 = North Carolina BC
                  00320 = North Dakota BC
                  00332 = Community Mutual Ins Co; Ohio-Administar
                  00340 = Oklahoma BC
                  00350 = Oregon BC
                  00351 = Oregon BC/ID.
                  00355 = Oregon-CWF
                  00362 = Independence BC - terminated 8/97
                  00363 = Veritus, Inc (PITTS)
                  00370 = Rhode Island BC
                  00380 = South Carolina BC
                  00390 = Tennessee BC
```

```
                              00400 = Texas BC
                              00410 = Utah BC
                              00423 = Virginia BC; Trigon
                              00430 = Washington/Alaska BC
                              00450 = Wisconsin BC
                              00452 = Michigan - Wisconsin BC
                              00454 = United Government Services -
                                      Wisconsin BC (eff. 12/00)
                              00460 = Wyoming BC
                              00468 = N Carolina BC/CPRTIVA
                              00993 = BC/BS Assoc.
                              17120 = Hawaii Medical Service
1         FI_NUM_TB                         Fiscal Intermediary Number Table
          ---------                         --------------------------------

                              50333 = Travelers; Connecticut United Healthcare
                                      (terminated - date unknown)
                              51051 = Aetna California - terminated 6/97
                              51070 = Aetna Connecticut - terminated 6/97
                              51100 = Aetna Florida - terminated 6/97
                              51140 = Aetna Illinois - terminated 6/97
                              51390 = Aetna Pennsylvania - terminated 6/97
                              52280 = Mutual of Omaha
                              57400 = Cooperative, San Juan, PR
                              61000 = Aetna


1    FI_RQST_CLM_CNCL_RSN_TB               Claim Cancel Reason Code Table
     ----------------------                ------------------------------


                              C = Coverage Transfer
                              D = Duplicate Billing
                              H = Other or blank
                              L = Combining two beneficiary master records
                              P = Plan Transfer
                              S = Scramble
                              ************For Action Code 4 ******************
                              *********Effective with HHPPS - 10/00***********
                              A = RAP/Final claim/LUPA is cancelled by Interme-
                                  diary.  Does not delete episode.  Do not set
                                  cancellation indicator.
                              B = RAP/Final claim/LUPA is cancelled by Interme-
                                  diary.  Does not delete episode.  Set
                                  cancellation indicator to 1.
                              E = RAP/Final claim/LUPA is cancelled by Interme-
                                  diary.  Remove episode.
                              F = RAP/Final claim/LUPA is cancelled by Provider.
                                  Remove episode.


1    GEO_SSA_STATE_TB                          State Table
     ----------------                          -----------


                              01 = Alabama
                              02 = Alaska
                              03 = Arizona
                              04 = Arkansas
                              05 = California
```

```
                         06 = Colorado
                         07 = Connecticut
                         08 = Delaware
                         09 = District of Columbia
                         10 = Florida
                         11 = Georgia
                         12 = Hawaii
                         13 = Idaho
                         14 = Illinois
                         15 = Indiana
                         16 = Iowa
                         17 = Kansas
                         18 = Kentucky
                         19 = Louisiana
                         20 = Maine
                         21 = Maryland
                         22 = Massachusetts
                         23 = Michigan
                         24 = Minnesota
                         25 = Mississippi
                         26 = Missouri
                         27 = Montana
                         28 = Nebraska
                         29 = Nevada
                         30 = New Hampshire
                         31 = New Jersey
                         32 = New Mexico
                         33 = New York
                         34 = North Carolina
                         35 = North Dakota
                         36 = Ohio
                         37 = Oklahoma
                         38 = Oregon
                         39 = Pennsylvania
                         40 = Puerto Rico
                         41 = Rhode Island
                         42 = South Carolina
                         43 = South Dakota
                         44 = Tennessee
                         45 = Texas
                         46 = Utah
                         47 = Vermont
                         48 = Virgin Islands
                         49 = Virginia
                         50 = Washington
                         51 = West Virginia
                         52 = Wisconsin
                         53 = Wyoming
                         54 = Africa
                         55 = Asia
                         56 = Canada & Islands
                         57 = Central America and West Indies
1        GEO_SSA_STATE_TB                              State Table
         ----------------                              -----------

                         58 = Europe
                         59 = Mexico
                         60 = Oceania
```

```
                  61 = Philippines
                  62 = South America
                  63 = U.S. Possessions
                  64 = American Samoa
                  65 = Guam
                  66 = Saipan
                  97 = Northern Marianas
                  98 = Guam
                  99 = With 000 county code is American Samoa;
                       otherwise unknown

1    HCFA_PRVDR_SPCLTY_TB                     HCFA Provider Specialty Table
     -------------------                      -----------------------------


                           **Prior to 5/92**

                  01 = General practice
                  02 = General surgery
                  03 = Allergy (revised 10/91 to mean allergy/
                       immunology)
                  04 = Otology, laryngology, rhinology
                       revised 10/91 to mean otolaryngology)
                  05 = Anesthesiology
                  06 = Cardiovascular disease (revised 10/91
                       to mean cardiology)
                  07 = Dermatology
                  08 = Family practice
                  09 = Gynecology--osteopaths only (deleted
                       10/91; changed to '16')
                  10 = Gastroenterology
                  11 = Internal medicine
                  12 = Manipulative therapy (osteopaths only)
                       (revised 10/91 to mean osteopathic
                       manipulative therapy)
                  13 = Neurology
                  14 = Neurological surgery (revised 10/91 to
                       mean neurosurgery)
                  15 = Obstetrics--osteopaths only (deleted
                       10/91; changed to '16')
                  16 = OB-gynecology
                  17 = Ophthalmology, otology, laryngology
                       rhinology--osteopaths only (deleted
                       10/91; changed to '18' if physicians
                       practice is more than 50% ophthalmology
                       or to '04' if physician's practice is
                       more than 50% otolaryngology.  If
                       practice is 50/50, choose specialty
                       with greater allowed charges.
                  18 = Ophthalmology
                  19 = Oral surgery (dentists only)
                  20 = Orthopedic surgery
                  21 = Pathologic anatomy, clinical pathology-
                       osteopaths only (deleted 10/91;
                       changed to '22')
                  22 = Pathology
                  23 = Peripheral vascular disease or surgery
                       (deleted 10/91; changed to '76')
```

```
             24 = Plastic surgery (revised to mean
                  plastic and reconstructive surgery).
             25 = Physical medicine and rehabilitation
             26 = Psychiatry
             27 = Psychiatry, neurology (osteopaths only)
                  (deleted 10/91; changed to '86')
             28 = Proctology (revised 10/91 to mean
                  colorectal surgery).
             29 = Pulmonary disease
             30 = Radiology (revised 10/91 to mean
                  diagnostic radiology)
             31 = Roentgenology, radiology (osteopaths)
                  (deleted 10/91; changed to '30')
             32 = Radiation therapy--osteopaths (deleted
```

```
  1    HCFA_PRVDR_SPCLTY_TB                  HCFA Provider Specialty Table
       --------------------                  ----------------------------
```

```
                  10/91; changed to '92')
             33 = Thoracic surgery
             34 = Urology
             35 = Chiropractor, licensed (revised 10/91
                  to mean chiropractic)
             36 = Nuclear medicine
             37 = Pediatrics (revised 10/91 to mean
                  pediatric medicine)
             38 = Geriatrics (revised 10/91 to mean
                  geriatric medicine)
             39 = Nephrology
             40 = Hand surgery
             41 = Optometrist - services related to
                  condition of aphakia (revised 10/91 to
                  mean optometrist)
             42 = Certified nurse midwife (added 7/88)
             43 = Certified registered nurse anesthetist
                  (revised 10/91 to mean CRNA,
                  anesthesia assistant)
             44 = Infectious disease
             46 = Endocrinology (added 10/91)
             48 = Podiatry - surgery chiropody (revised
                  10/91 to mean podiatry)
             49 = Miscellaneous (include ASCS)
             51 = Medical supply company with C.O.
                  certification (certified orthotist -
                  certified by American Board for
                  Certification in Prosthetics and
                  Orthotics.
             52 = Medical supply company with C.P.
                  certification (certified prosthetist -
                  certified by American Board for
                  Certification in Prosthetics and Orthotics).
             53 = Medical supply company with C.P.O.
                  certification (certified prosthetist -
                  orthotist - certified by American
                  Board for Certification in Prosthetics
                  and Orthotics).
             54 = Medical supply company not included in
                  51, 52, or 53.
             55 = Individual certified orthotist
```

```
                         56 = Individual certified prosthetist
                         57 = Individual certified prosthetist -
                              orthotist
                         58 = Individuals not included in 55,56 or 57
                         59 = Ambulance service supplier (e.g.
                              private ambulance companies, funeral
                              homes, etc.)
                         60 = Public health or welfare agencies
                              (federal, state, and local)
                         61 = Voluntary health or charitable agencies
                              (e.g. National Cancer Society, National
                              Heart Association, Catholic Charities)
                         62 = Psychologist--billing independently
                         63 = Portable X-ray supplier--billing
                              independently (revised 10/91 to mean
                              portable X-ray supplier)
                         64 = Audiologist (billing independently)
  1    HCFA_PRVDR_SPCLTY_TB                 HCFA Provider Specialty Table
       --------------------                 ----------------------------

                         65 = Physical therapist (independent practice)
                         66 = Rheumatology (added 10/91)
                         67 = Occupational therapist--independent
                              practice
                         68 = Clinical psychologist
                         69 = Independent laboratory--billing
                              independently (revised 10/91 to mean
                              independent clinical laboratory --
                              billing independently)
                         70 = Clinic or other group practice, except
                              Group Practice Prepayment Plan (GPPP)
                         71 = Group Practice Prepayment Plan - diagnostic
                              X-ray (do not use after 1/92)
                         72 = Group Practice Prepayment Plan - diagnostic
                              laboratory (do not use after 1/92)
                         73 = Group Practice Prepayment Plan -
                              physiotherapy (do not use after 1/92)
                         74 = Group Practice Prepayment Plan - occupational
                              therapy (do not use after 1/92)
                         75 = Group Practice Prepayment Plan - other
                              medical care (do not use after 1/92)
                         76 = Peripheral vascular disease
                              (added 10/91)
                         77 = Vascular surgery (added 10/91)
                         78 = Cardiac surgery (added 10/91)
                         79 = Addiction medicine (added 10/91)
                         8O = Clinical social worker (1991)
                         81 = Critical care-intensivists (added 10/91)
                         82 = Ophthalmology, cataracts specialty
                              (added 10/91; used only until 5/92)
                         83 = Hematology/oncology (added 10/91)
                         84 = Preventive medicine (added 10/91)
                         85 = Maxillofacial surgery (added 10/91)
                         86 = Neuropsychiatry (added 10/91)
                         87 = All other (e.g. drug and department
                              stores) (revised 10/91 to mean all
                              other suppliers)
                         88 = Unknown (revised 10/91 to mean
```

```
                  physician assistant)
           90 = Medical oncology (added 10/91)
           91 = Surgical oncology (added 10/91)
           92 = Radiation oncology (added 10/91)
           93 = Emergency medicine (added 10/91)
           94 = Interventional radiology (added 10/91)
           95 = Independent physiological laboratory
                  (added 10/91)
           96 = Unknown physician specialty
                  (added 10/91)
           99 = Unknown--incl. social worker's
                  psychiatric services (revised 10/91 to
                  mean unknown supplier/provider)
                  --------------------------------------
                          **Effective 5/92**

           00 = Carrier wide
           01 = General practice
           02 = General surgery
           03 = Allergy/immunology
1     HCFA_PRVDR_SPCLTY_TB                    HCFA Provider Specialty Table
      --------------------                    ----------------------------

           04 = Otolaryngology
           05 = Anesthesiology
           06 = Cardiology
           07 = Dermatology
           08 = Family practice
           09 = Gynecology (osteopaths only)
                  (discontinued 5/92 use code 16)
           10 = Gastroenterology
           11 = Internal medicine
           12 = Osteopathic manipulative therapy
           13 = Neurology
           14 = Neurosurgery
           15 = Obstetrics (osteopaths only)
                  (discontinued 5/92 use code 16)
           16 = Obstetrics/gynecology
           17 = Ophthalmology, otology, laryngology,
                  rhinology (osteopaths only)
                  (discontinued 5/92 use codes 18 or 04
                  depending on percentage of practice)
           18 = Ophthalmology
           19 = Oral surgery (dentists only)
           20 = Orthopedic surgery
           21 = Pathologic anatomy, clinical
                  pathology (osteopaths only)
                  (discontinued 5/92 use code 22)
           22 = Pathology
           23 = Peripheral vascular disease, medical
                  or surgical (osteopaths only)
                  (discontinued 5/92 use code 76)
           24 = Plastic and reconstructive surgery
           25 = Physical medicine and rehabilitation
           26 = Psychiatry
           27 = Psychiatry, neurology (osteopaths
                  only) (discontinued 5/92 use code 86)
           28 = Colorectal surgery (formerly
```

```
                        proctology)
              29 = Pulmonary disease
              30 = Diagnostic radiology
              31 = Roentgenology, radiology (osteopaths
                   only) (discontinued 5/92 use code 30)
              32 = Radiation therapy (osteopaths only)
                   (discontinued 5/92 use code 92)
              33 = Thoracic surgery
              34 = Urology
              35 = Chiropractic
              36 = Nuclear medicine
              37 = Pediatric medicine
              38 = Geriatric medicine
              39 = Nephrology
              40 = Hand surgery
              41 = Optometry (revised 10/93 to
                   mean optometrist)
              42 = Certified nurse midwife (eff 1/87)
              43 = Crna, anesthesia assistant
                   (eff 1/87)
              44 = Infectious disease
              45 = Mammography screening center
              46 = Endocrinology (eff 5/92)
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
        --------------------   ----------------------------

```
              47 = Independent Diagnostic Testing Facility
                   (IDTF) (eff. 6/98)
              48 = Podiatry
              49 = Ambulatory surgical center
                   (formerly miscellaneous)
              50 = Nurse practitioner
              51 = Medical supply company with
                   certified orthotist (certified by
                   American Board for Certification in
                   Prosthetics And Orthotics)
              52 = Medical supply company with
                   certified prosthetist
                   (certified by American Board for
                   Certification In Prosthetics And
                   Orthotics)
              53 = Medical supply company with
                   certified prosthetist-orthotist
                   (certified by American Board for
                   Certification in Prosthetics
                   and Orthotics)
              54 = Medical supply company not included
                   in 51, 52, or 53.  (Revised 10/93
                   to mean medical supply company for DMERC)
              55 = Individual certified orthotist
              56 = Individual certified prosthetist
              57 = Individual certified prosthetist-
                   orthotist
              58 = Individuals not included in 55, 56,
                   or 57 (revised 10/93  to mean medical
                   supply company with registered
                   pharmacist)
              59 = Ambulance service supplier, e.G.,
```

```
                        private ambulance companies, funeral
                        homes, etc.
            60 = Public health or welfare agencies
                 (federal, state, and local)
            61 = Voluntary health or charitable
                 agencies (e.G., National Cancer
                 Society, National Heart Associiation,
                 Catholic Charities)
            62 = Psychologist (billing independently)
            63 = Portable X-ray supplier
            64 = Audiologist (billing independently)
            65 = Physical therapist (independently
                 practicing)
            66 = Rheumatology (eff 5/92)
                 Note: during 93/94 DMERC also used this
                 to mean medical supply company with
                 respiratory therapist
            67 = Occupational therapist (independently
                 practicing)
            68 = Clinical psychologist
            69 = Clinical laboratory (billing
                 independently)
            70 = Multispecialty clinic or group
                 practice
            71 = Diagnostic X-ray (GPPP) (not to
                 be assigned after 5/92)
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
       --------------------   ----------------------------

```
            72 = Diagnostic laboratory (GPPP)
                 (not to be assigned after 5/92)
            73 = Physiotherapy (GPPP) (not to be
                 assigned after 5/92)
            74 = Occupational therapy (GPPP)
                 (not to be assigned after 5/92)
            75 = Other medical care (GPPP) (not to
                 assigned after 5/92)
            76 = Peripheral vascular disease
                 (eff 5/92)
            77 = Vascular surgery (eff 5/92)
            78 = Cardiac surgery (eff 5/92)
            79 = Addiction medicine (eff 5/92)
            80 = Licensed clinical social worker
            81 = Critical care (intensivists)
                 (eff 5/92)
            82 = Hematology (eff 5/92)
            83 = Hematology/oncology (eff 5/92)
            84 = Preventive medicine (eff 5/92)
            85 = Maxillofacial surgery (eff 5/92)
            86 = Neuropsychiatry (eff 5/92)
            87 = All other suppliers (e.g. drug and
                 department stores) (note: DMERC used
                 87 to mean department store from 10/93
                 through 9/94; recoded eff 10/94 to A7;
                 NCH cross-walked DMERC reported 87 to A7.
            88 = Unknown supplier/provider specialty
                 (note: DMERC used 87 to mean grocery
                 store from 10/93 - 9/94; recoded eff
```

10/94 to A8; NCH cross-walked DMERC
                         reported 88 to A8.
                    89 = Certified clinical nurse specialist
                    90 = Medical oncology (eff 5/92)
                    91 = Surgical oncology (eff 5/92)
                    92 = Radiation oncology (eff 5/92)
                    93 = Emergency medicine (eff 5/92)
                    94 = Interventional radiology (eff 5/92)
                    95 = Independent physiological
                         laboratory (eff 5/92)
                    96 = Optician (eff 10/93)
                    97 = Physician assistant (eff 5/92)
                    98 = Gynecologist/oncologist (eff 10/94)
                    99 = Unknown physician specialty
                    A0 = Hospital (eff 10/93) (DMERCs only)
                    A1 = SNF (eff 10/93) (DMERCs only)
                    A2 = Intermediate care nursing facility
                         (eff 10/93) (DMERCs only)
                    A3 = Nursing facility, other (eff 10/93)
                         (DMERCs only)
                    A4 = HHA (eff 10/93) (DMERCs only)
                    A5 = Pharmacy (eff 10/93) (DMERCs only)
                    A6 = Medical supply company with respiratory
                         therapist (eff 10/93) (DMERCs only)
                    A7 = Department store (for DMERC use:
                         eff 10/94, but cross-walked from
                         code 87 eff 10/93)
                    A8 = Grocery store (for DMERC use:
                         eff 10/94, but cross-walked from
1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
      --------------------   -----------------------------

                         code 88 eff 10/93)

1   HCFA_TYPE_SRVC_TB   HCFA Type of Service Table
      -----------------   --------------------------

                    1 = Medical care
                    2 = Surgery
                    3 = Consultation
                    4 = Diagnostic radiology
                    5 = Diagnostic laboratory
                    6 = Therapeutic radiology
                    7 = Anesthesia
                    8 = Assistant at surgery
                    9 = Other medical items or services
                    0 = Whole blood only eff 01/96,
                        whole blood or packed red cells before 01/96
                    A = Used durable medical equipment (DME)
                    B = High risk screening mammography
                        (obsolete 1/1/98)
                    C = Low risk screening mammography
                        (obsolete 1/1/98)
                    D = Ambulance (eff 04/95)
                    E = Enteral/parenteral nutrients/supplies
                        (eff 04/95)
                    F = Ambulatory surgical center (facility

```
                    usage for surgical services)
                G = Immunosuppressive drugs
                H = Hospice services (discontinued 01/95)
                I = Purchase of DME (installment basis)
                    (discontinued 04/95)
                J = Diabetic shoes (eff 04/95)
                K = Hearing items and services (eff 04/95)
                L = ESRD supplies (eff 04/95)
                    (renal supplier in the home before 04/95)
                M = Monthly capitation payment for dialysis
                N = Kidney donor
                P = Lump sum purchase of DME, prosthetics,
                    orthotics
                Q = Vision items or services
                R = Rental of DME
                S = Surgical dressings or other medical supplies
                    (eff 04/95)
                T = Psychological therapy (term. 12/31/97)
                    outpatient mental health limitation (eff. 1/1/98)
                U = Occupational therapy
                V = Pneumococcal/flu vaccine (eff 01/96),
                    Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
                    Pneumococcal only before 04/95
                W = Physical therapy
                Y = Second opinion on elective surgery
                    (obsoleted 1/97)
                Z = Third opinion on elective surgery
                    (obsoleted 1/97)


1 LINE_ADDTNL_CLM_DCMTN_IND_TB          Line Additional Claim Documentation Indicator Table
  --------------------------            ---------------------------------------------------


                0 = No additional documentation
                1 = Additional documentation submitted for
                    non-DME EMC claim
                2 = CMN/prescription/other documentation submitted
                    which justifies medical necessity
                3 = Prior authorization obtained and approved
                4 = Prior authorization requested but not approved
                5 = CMN/prescription/other documentation submitted
                    but did not justify medical necessity
                6 = CMN/prescription/other documentation submitted
                    and approved after prior authorization rejected
                7 = Recertification CMN/prescription/other
                    documentation

1       LINE_PLC_SRVC_TB                       Line Place Of Service Table
        ----------------                       ---------------------------


                        **Prior To 1/92**

                1 = Office
                2 = Home
                3 = Inpatient hospital
                4 = SNF
                5 = Outpatient hospital
```

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                  6 = Independent lab
                  7 = Other
                  8 = Independent kidney disease treatment
                      center
                  9 = Ambulatory
                  A = Ambulance service
                  H = Hospice
                  M = Mental health, rural mental health
                  N = Nursing home
                  R = Rural codes


                  ----------------------------------------
                          **Effective 1/92**

                  11 = Office
                  12 = Home
                  21 = Inpatient hospital
                  22 = Outpatient hospital
                  23 = Emergency room - hospital
                  24 = Ambulatory surgical center
                  25 = Birthing center
                  26 = Military treatment facility
                  31 = Skilled nursing facility
                  32 = Nursing facility
                  33 = Custodial care facility
                  34 = Hospice
                  35 = Adult living care facilities (ALCF)
                       (eff. NYD - added 12/3/97)
                  41 = Ambulance - land
                  42 = Ambulance - air or water
                  50 = Federally qualified health centers
                       (eff. 10/1/93)
                  51 = Inpatient psychiatric facility
                  52 = Psychiatric facility partial hospitalization
                  53 = Community mental health center
                  54 = Intermediate care facility/mentally
                       retarded
                  55 = Residential substance abuse treatment
                       facility
                  56 = Psychiatric residential treatment
                       center
                  60 = Mass immunizations center (eff. 9/1/97)
                  61 = Comprehensive inpatient rehabilitation
                       facility
                  62 = Comprehensive outpatient rehabilitation
                       facility
                  65 = End stage renal disease treatment facility
                  71 = State or local public health clinic
                  72 = Rural health clinic
                  81 = Independent laboratory
1      LINE_PLC_SRVC_TB                      Line Place Of Service Table
       ----------------                      ---------------------------


                  99 = Other unlisted facility

1      LINE_PMT_IND_TB                       Line Payment Indicator Table
       ---------------                       ----------------------------
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                          1 = Actual charge
                          2 = Customary charge
                          3 = Prevailing charge (adjusted, unadjusted
                              gap fill, etc)
                          4 = Other (ASC fees, radiology and
                              outpatient limits, and non-payment
                              because of denial.
                          5 = Lab fee schedule
                          6 = Physician fee schedule - full fee
                              schedule amount
                          7 = Physician fee schedule - transition
                          8 = Clinical psychologist fee schedule
                          9 = DME and prosthetics/orthotics fee
                              schedules (eff. 4/97)

1      LINE_PRCSG_IND_TB                     Line Processing Indicator Table
       -----------------                     -------------------------------


                          A = Allowed
                          B = Benefits exhausted
                          C = Noncovered care
                          D = Denied (existed prior to 1991; from
                              BMAD)
                          I = Invalid data
                          L = CLIA (eff 9/92)
                          M = Multiple submittal--duplicate line item
                          N = Medically unnecessary
                          O = Other
                          P = Physician ownership denial (eff 3/92)
                          Q = MSP cost avoided (contractor #88888) -
                              voluntary agreement (eff. 1/98)
                          R = Reprocessed--adjustments based on
                              subsequent reprocessing of claim
                          S = Secondary payer
                          T = MSP cost avoided - IEQ contractor
                              (eff. 7/76)
                          U = MSP cost avoided - HMO rate cell
                              adjustment (eff. 7/96)
                          V = MSP cost avoided - litigation
                              settlement (eff. 7/96)
                          X = MSP cost avoided - generic
                          Y = MSP cost avoided - IRS/SSA data
                              match project
                          Z = Bundled test, no payment
                              (eff. 1/1/98)

1  LINE_PRVDR_PRTCPTG_IND_TB              Line Provider Participating Indicator Table
   -------------------------              -------------------------------------------


                          1 = Participating
                          2 = All or some covered and allowed
                              expenses applied to deductible Participating
                          3 = Assignment accepted/non-participating
                          4 = Assignment not accepted/non-participating
                          5 = Assignment accepted but all or some
```

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                           covered and allowed expenses applied
                           to deductible Non-participating.
                       6 = Assignment not accepted and all covered
                           and allowed expenses applied to deductible
                           non-participating.
                       7 = Participating provider not accepting
                           assignment.

1      NCH_CLM_TYPE_TB                              NCH Claim Type Table
       ---------------                              --------------------


                       10 = HHA claim
                       20 = Non swing bed SNF claim
                       30 = Swing bed SNF claim
                       40 = Outpatient claim
                       41 = Outpatient 'Full-Encounter' claim
                            (available in NMUD)
                       42 = Outpatient 'Abbreviated-Encounter' claim
                            (available in NMUD)
                       50 = Hospice claim
                       60 = Inpatient claim
                       61 = Inpatient 'Full-Encounter' claim
                       62 = Inpatient 'Abbreviated-Encounter claim
                            (available in NMUD)
                       71 = RIC O local carrier non-DMEPOS claim
                       72 = RIC O local carrier DMEPOS claim
                       73 = Physician 'Full-Encounter' claim
                            (available in NMUD)
                       81 = RIC M DMERC non-DMEPOS claim
                       82 = RIC M DMERC DMEPOS claim


1      NCH_EDIT_TB                                  NCH EDIT TABLE
       -----------                                  --------------


                       A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
                       A000 = (C) REIMB > $100,000 OR UNITS > 150
                       A002 = (C) CLAIM IDENTIFIER (CAN)
                       A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
                       A004 = (C) PATIENT SURNAME BLANK
                       A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                       A006 = (C) DATE OF BIRTH IS NOT NUMERIC
                       A007 = (C) INVALID GENDER (0, 1, 2)
                       A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
                       A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
                       A1X1 = (C) PERCENT ALLOWED INDICATOR
                       A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
                       A1X3 = (C) DT>96365,DIAG=V725
                       A1X4 = (C) INVALID DIAGNOSTIC CODES
                       C050 = (U) HOSPICE - SPELL VALUE INVALID
                       D102 = (C) DME DATE OF BIRTH INVALID
                       D2X2 = (C) DME SCREEN SAVINGS INVALID
                       D2X3 = (C) DME SCREEN RESULT INVALID
                       D2X4 = (C) DME DECISION IND INVALID
                       D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
                       D3X1 = (C) DME NATIONAL DRUG CODE INVALID
                       D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
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            D4X2 = (C) DME OUT OF DMERC SERVICE AREA
            D4X3 = (C) DME STATE CODE INVALID
            D5X1 = (C) TOS INVALID FOR DME HCPCS
            D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
            D5X3 = (C) DME INVALID USE OF MS MODIFIER
            D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
            D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
            D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
            D6X1 = (C) DME SUPPLIER NUMBER MISSING
            D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
            D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
            D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
            XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
            Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
            Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
            Y003 = (C) HCPCS R0075/UNITS=SERVICES
            Y010 = (C) TOB=13X/14X AND T.C.>$7,500
            Y011 = (C) INP CLAIM/REIM > $75,000
            Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
            Z002 = (C) CC M2 PRESENT/REIMB > $150,000
            Z003 = (C) CC M2 PRESENT/UNITS > 150
            Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
            Z005 = (C) REIMB>99999 AND REIMB<150000
            Z006 = (C) UNITS>99 AND UNITS<150
            Z237 = (E) HOSPICE OVERLAP - DATE ZERO
            0011 = (C) ACTION CODE INVALID
            0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
            0014 = (C) DEMO NUM NOT=01-06,08,15,31
            0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
            0016 = (C) INVALID VA CLAIM
            0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
            0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
            0020 = (C) CANCEL ONLY CODE INVALID
            0021 = (C) DEMO COUNT > 1
            0301 = (C) INVALID HI CLAIM NUMBER
```

```
            0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
            04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
            04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
            0401 = (C) BILL TYPE/PROVIDER INVALID
            0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
            0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
            0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
            0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
            0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
            0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
            0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
            0414 = (C) VALU CD 61,MSA AMOUNT MISSING
            0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
            05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
            05X5 = (C) UPIN REQUIRED FOR DME HCPCS
            0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
            0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
            0601 = (C) GENDER INVALID
            0701 = (C) CONTRACTOR INVALID CARRIER/ETC
            0702 = (C) PROVIDER NUMBER INCONSISTANT
```

```
              0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
              0704 = (C) INVALID CONT FOR CABG DEMO
              0705 = (C) INVALID CONT FOR PCOE DEMO
              0901 = (C) INVALID DISP CODE OF 02
              0902 = (C) INVALID DISP CODE OF SPACES
              0903 = (C) INVALID DISP CODE
              1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
              13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
              1301 = (C) LINE COUNT NOT NUMERIC OR > 13
              1302 = (C) RECORD LENGTH INVALID
              1401 = (C) INVALID MEDICARE STATUS CODE
              1501 = (C) ADMIT DATE/ENTRY CODE INVALID
              1502 = (C) ADMIT DATE > STAY FROM DATE
              1503 = (C) ADMIT DATE INVALID WITH THRU DATE
              1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
              1505 = (C) HCPCS W SERVICE DATES > 09-30-94
              1601 = (C) INVESTIGATION IND INVALID
              1701 = (C) SPLIT IND INVALID
              1801 = (C) PAY-DENY CODE INVALID
              1802 = (C) HEADER AMT AND NOT DENIED CLAIM
              1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
              1901 = (C) AB CROSSOVER IND INVALID
              2001 = (C) HOSPICE OVERRIDE INVALID
              2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
              2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
              2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
              2202 = (C) STAY-FROM DATE > THRU-DATE
              2203 = (C) THRU DATE INVALID
              2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
              2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
              2207 = (C) MAMMOGRAPHY BEFORE 1991
              2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
              2302 = (C) COVERED DAYS INVALID OR INCONSIST
              2303 = (C) COST REPORT DAYS > ACCOMIDATION
              2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
              2305 = (C) UTIL DAYS = INCONSISTENCIES
              2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
              2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
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1   NCH_EDIT_TB   NCH EDIT TABLE
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              2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
              2401 = (C) NON-UTIL DAYS INVALID
              2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
              2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
              2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
              2504 = (C) COINSURANCE AMOUNT EXCESSIVE
              2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
              2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
              2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
              2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
              2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
              2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
              2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
              2604 = (C) PPS BILL, NO DAY OUTLIER
              2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
              28XA = (C) UTIL DAYS > FROM TO BENEF EXH
              28XB = (C) BENEFITS EXH DATE > FROM DATE
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```
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID
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1        NCH_EDIT_TB                          NCH EDIT TABLE
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4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
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46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK
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51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
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                         5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
                         5169 = (U) PROVIDER NE TO WORK PROVIDER
                         5177 = (U) PROVIDER NE TO WORK PROVIDER
                         5178 = (U) HOSPICE BILL THRU < DOLBA
                         5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
                         5200 = (E) ENTITLEMENT EFFECTIVE DATE
                         5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
                         5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
                         5202 = (U) HOSPICE TRAILER ERROR
                         5203 = (E) ENTITLEMENT HOSPICE PERIODS
                         5203 = (U) HOSPICE START DATE ERROR
                         5204 = (U) HOSPICE DATE DIFFERENCE NE 90
                         5205 = (U) HOSPICE DATE DISCREPANCY
                         5206 = (U) HOSPICE DATE DISCREPANCY
                         5207 = (U) HOSPICE THRU > TERM DATE 2ND
                         5208 = (U) HOSPICE PERIOD NUMBER BLANK
                         5209 = (U) HOSPICE DATE DISCREPANCY
                         5210 = (E) ENTITLEMENT FRM/TRU/END DATES
                         5211 = (E) ENTITLEMENT DATE DEATH/THRU
                         5212 = (E) ENTITLEMENT DATE DEATH/THRU
                         5213 = (E) ENTITLEMENT DATE DEATH MBR
                         5220 = (E) ENTITLEMENT FROM/EFF DATES
                         5225 = (E) ENT INP PPS SPAN 70 DATES
                         5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
                         5233 = (E) ENTITLEMENT HMO PERIODS
                         5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
                         5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
                         5236 = (E) ENTITLEMENT HMO HOSP + CC07
                         5237 = (E) ENTITLEMENT HOSP OVERLAP
                         5238 = (U) HOSPICE CLAIM OVERLAP > 90
                         5239 = (U) HOSPICE CLAIM OVERLAP > 60
                         524Z = (E) HOSP OVERLAP NO OVD NO DEMO
                         5240 = (U) HOSPICE DAYS STAY+USED > 90
                         5241 = (U) HOSPICE DAYS STAY+USED > 60
                         5242 = (C) INVALID CARRIER FOR RRB
                         5243 = (C) HMO=90091,INVALID SERVICE DTE
                         5244 = (E) DEMO CABG/PCOE MISSING ENTL
                         5245 = (C) INVALID CARRIER FOR NON RRB
                         525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
                         5250 = (U) HOSPICE DOEBA/DOLBA
                         5255 = (U) HOSPICE DAYS USED
                         5256 = (U) HOSPICE DAYS USED > 999
                         526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
                         526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
                         527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
                         527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
                         5299 = (U) HOSPICE PERIOD NUMBER ERROR
1        NCH_EDIT_TB                                   NCH EDIT TABLE
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                         5320 = (U) BILL > DOEBA AND IND-1 = 2
                         5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
                         5355 = (U) HOSPICE DAYS USED SECONDARY
                         5378 = (C) SERVICE DATE < AGE 50
                         5399 = (U) HOSPICE PERIOD NUM MATCH
                         5410 = (U) INPAT DEDUCTABLE
                         5425 = (U) PART B DEDUCTABLE CHECK
                         5430 = (U) PART B DEDUCTABLE CHECK
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5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID
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```
6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
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              61X2 = (C) DENIED CLAIM/NO DENIED LINE
              61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
              61X4 = (C) RATE MISSING OR NON-NUMERIC
              6100 = (C) REV 0001 NOT PRESENT ON CLAIM
              6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
              6102 = (C) REV COMPUTED NON-COVERED/NON-COV
              6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
              62XA = (C) PSYC OT PT/REIM/TYPE
              62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
              62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
              62X8 = (C) KIDNEY DONO/TYPE/100%
              62X9 = (C) PNEUM VACCINE/TYPE/100%
              6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
              6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
              6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
              6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
              6261 = (U) HOSPICE ADJUSTMENT DAYS USED
              6265 = (U) HOSPICE ADJUSTMENT DAYS USED
              6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
              63X1 = (C) DEDUCT IND INVALID
              63X2 = (C) DED/HCFA COINS IN PCOE/CABG
              6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
              6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
              64X1 = (C) PROVIDER IND INVALID
              6430 = (U) PART B DEDUCTABLE CHECK
              65X1 = (C) PAYSCREEN IND INVALID
              66?? = (D) POSS DUPE, CR/DB, DOC-ID
              66XX = (D) POSS DUPE, CR/DB, DOC-ID
              66X1 = (C) UNITS AMOUNT INVALID
              66X2 = (C) UNITS IND > 0; AMT NOT VALID
              66X3 = (C) UNITS IND = 0; AMT > 0
              66X4 = (C) MT INDICATOR/AMOUNT
              6600 = (U) ADJUSTMENT BILL FULL DAYS
              6610 = (U) ADJUSTMENT BILL COIN DAYS
              6620 = (U) ADJUSTMENT BILL LIFE RESERVE
              6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
              67X1 = (C) UNITS INDICATOR INVALID
              67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
              67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
              67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
              67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
              67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
              67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
              6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
              6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
              68X1 = (C) INVALID HCPCS CODE
              68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
              68X3 = (C) TYPE OF SERVICE = G /PROC CODE
              68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
              68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
              68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
              68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
              68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.
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              69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
              69X3 = (C) PROC CODE MOD = LL / TYPE = R
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       69X6 = (C) PROC CODE MOD/NOT CAPPED
       69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
       6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
       6902 = (C) KRON IND AND NO-PAY CODE B OR N
       6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
       6904 = (C) KRON IND AND TRANS CODE IS 4
       6910 = (C) REV CODES ON HOME HEALTH
       6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
       6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
       6913 = (C) REV CODE INVAL FOR OXYGEN
       6914 = (C) REV CODE INVAL FOR DME
       6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
       6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
       6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
       6918 = (C) HCPCS INVALID ON DATE RANGES
       6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
       6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
       6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
       6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
       6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
       6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
       6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
       6929 = (U) ADJUSTMENT BILL LIFE RESERVE
       6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
       7000 = (U) INVALID DOEBA/DOLBA
       7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
       7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
       71X1 = (C) SUBMITTED CHARGES INVALID
       71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
       72X1 = (C) ALLOWED CHGS INVALID
       72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
       72X3 = (C) DENIED LINE/ALLOWED CHARGES
       73X1 = (C) SS NUMBER INVALID
       73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
       74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
       76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
       77X1 = (C) PLACE OF SERVICE INVALID
       77X2 = (C) PHYS THERAPY/PLACE
       77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
       77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
       77X6 = (C) TOS=F, PL OF SER NOT = 24
       7701 = (C) INCORRECT MODIFIER
       7777 = (D) POSS DUPE, PART B DOC-ID
       78XA = (C) MAMMOGRAPHY BEFORE 1991
       78X1 = (C) THRU DATE INVALID
       78X3 = (C) FROM DATE GREATER THAN THRU DATE
       78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
       78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
       78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
       79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
       79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
       8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
       8028 = (E) NO ENTITLEMENT
       8029 = (U) HH BEFORE PERIOD NOT PRESENT
       8030 = (U) HH BILL VISITS > PT A REMAINING
       8031 = (U) HH PT A REMAINING > 0
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8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
```

```
                                     94G1 = (C) NO-PAY CODE INVALID
1         NCH_EDIT_TB                                 NCH EDIT TABLE
          -----------                                 --------------

                                     94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
                                     94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
                                     94G4 = (C) NO PAY CODE = R & REIMB PRESENT
                                     94X1 = (C) BLOOD LIMIT INVALID
                                     94X2 = (C) TYPE/BLOOD DEDUCTIBLE
                                     94X3 = (C) TYPE/DATE/LIMIT AMOUNT
                                     94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
                                     94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
                                     9401 = (C) BLOOD DEDUCTIBLE AMT > 3
                                     9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
                                     9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
                                     9404 = (C) INVALID GENDER CODE ON PRO-PAY
                                     9407 = (C) INVALID DRG NUMBER
                                     9408 = (C) INVALID DRG NUMBER (GLOBAL)
                                     9409 = (C) HCFA DRG<>DRG ON BILL
                                     9410 = (C) CABG/PCOE,INVALID DRG
                                     95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
                                     95X2 = (C) MSP AMOUNT APPLIED INVALID
                                     95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
                                     95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
                                     95X5 = (C) MSP CODE = G/DATE BEFORE 1987
                                     95X6 = (C) MSP CODE = X AND NOT AVOIDED
                                     95X7 = (C) MSP CODE VALID, CABG/PCOE
                                     96X1 = (C) OTHER AMOUNTS INVALID
                                     96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
                                     97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
                                     97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
                                     98X1 = (C) COINSURANCE INVALID
                                     98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
                                     98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
                                     98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
                                     99XX = (D) POSS DUPE, PART B DOC-ID
                                     9901 = (C) REV CODE INVALID OR TRAILER CNT=0
                                     9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
                                     9903 = (C) NO CLINIC VISITS FOR RHC
                                     9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
                                     991X = (C) NO DATE OF SERVICE
                                     9910 = (C) EDIT 9910 (NEW)
                                     9911 = (C) BLOOD VERIFIED INVALID
                                     9920 = (C) EDIT 9920 (NEW)
                                     9930 = (C) EDIT 9930 (NEW)
                                     9931 = (C) OUTPAT COINSURANCE VALUES
                                     9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
                                     9940 = (C) EDIT 9940 (NEW)
                                     9942 = (C) EDIT 9942 (NEW)
                                     9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
                                     9945 = (C) SERVICE DATE < 98001
                                     9946 = (C) INVALID DIAGNOSIS CODE
                                     9947 = (C) INVALID DIAGNOSIS CODE
                                     9948 = (C) STAY FROM>96365,DIAG=V725
                                     9960 = (C) MED CHOICE BUT HMO DATA MISSING
                                     9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
                                     9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
```

```
1    NCH_IP_PRO_APRVL_TYPE_TB         NCH Inpatient Peer Review Organization Approval Type Table
     -----------------------          ----------------------------------------------------------


                                 1 = Approved by the PRO as billed - Code
                                     indicates that the claim has been
                                     reviewed by the PRO and has been fully
                                     approved including any day or cost
                                     outliers.
                                 2 = Automatic approval - Does not apply to
                                     Medicare claim.
                                 3 = Partial approval - Code indicates the
                                     bill has been reviewed by the PRO, and
                                     some portion (days or services) has
                                     been denied.  The from/thru dates of
                                     the approved portion of the stay,
                                     excluding grace days and any period at
                                     a noncovered level of care are shown
                                     on the bill.
                                 4 = Admission denied - Code indicates the
                                     patient's need for inpatient services
                                     was reviewed upon admission and the
                                     PRO found that the stay was not
                                     medically necessary.
                                 5 = Post payment review - Code indicates
                                     that any medical review will be
                                     completed after the claim is paid.
                                     The bill may be a day outlier, part of
                                     the sample review, or may not be
                                     reviewed.
                                 6 = Pre-admission authorization - Pre-
                                     admission authorization obtained, but
                                     services not reviewed by the PRO.
                                 7 THRU 9 = Reserved.

1    NCH_NEAR_LINE_RIC_TB             NCH Near-Line Record Identification Code Table
     --------------------             ---------------------------------------------


                                 O = Part B physician/supplier claim
                                     record (processed by local carriers;
                                     can include DMEPOS services)
                                 V = Part A institutional claim record
                                     (inpatient (IP), skilled nursing
                                     facility (SNF), christian science
                                     (CS), home health agency (HHA), or
                                     hospice)
                                 W = Part B institutional claim record
                                     (outpatient (OP), HHA)
                                 U = Both Part A and B institutional home
                                     health agency (HHA) claim records --
                                     due to HHPPS and HHA A/B split.
                                     (effective 10/00)
                                 M = Part B DMEPOS claim record (processed
                                     by DME Regional Carrier) (effective 10/93)

1    NCH_PATCH_TB                     NCH Patch Table
     ------------                     ---------------
```

```
01 = RRB Category Equatable BIC - changed (all
     claim types) -- applied during the Nearline
     'G' conversion to claims with NCH weekly
     process date before 3/91.   Prior to Version
     'H', patch indicator stored in redefined Claim
     Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with
     NCH payment/edit RIC code (OP and HHA) --
     effective 3/94, CWFMQA began patch.  During
     'H' conversion, patch applied to claims with
     NCH weekly process date prior to 3/94.  Prior
     to version 'H', patch indicator stored in
     redefined Claim Edit Group, 4th occurrence,
     position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount
     set to zeroes (Instnl) --  during the Version
     'G' conversion, error occurred in the deriva-
     tion of this field where the claim was missing
     revenue center code = '0001'.   In 1994, patch
     was applied to the OP and HHA SAFs only. (This
     SAF patch indicator was stored in the redefined
     Claim Edit Group, 4th occurrence, position 2).
     During the 'H' ocnversion, patch applied to
     Nearline claims where garbage or nonnumeric
     values.
04 = Incorrect bene residence SSA standard county
     code '999' changed (all claim types) --
     applied during the Nearline 'G' conversion and
     ongoing through 4/21/94, calling EQSTZIP
     routine to claims with NCH weekly process
     date prior to 4/22/94.  Prior to Version 'H'
     patch indicator stored in redefined Claim
     Edit Group, 3rd occurrence, position 4.
05 = Wrong century bene birth date corrected (all
     claim types) -- applied during Nearline 'H'
     conversion to all history where century
     greater than 1700 and less than 1850; if
     century less than 1700, zeroes moved.
06 = Inconsistent CWF bene medicare status code
     made consistent with age (all claim types) --
     applied during Nearline 'H' conversion to all
     history and patched ongoing.  Bene age is
     calculated to determine the correct value;
     if greater than 64, 1st position MSC ='1';
     if less than 65, 1st position MSC = '2'.
07 = Missing CWF bene mediare status code derived
     (all claim types) -- applied during Nearline
     'H' conversion to all history and patched
     ongoing, except claims with unknown DOB and/
     or Claim From Date='0' (left blank).   Bene
     age is calculated to determine missing value;
     if greater than 64, MSC='10'; if less than
     65, MSC = '20'.
08 = Invalid NCH primary payer code set to blanks
     (Instnl) -- applied during Version 'H' con-
     version to claims with NCH weekly process
```

```
                                          date 10/1/93-10/30/95, where MSP values =
1       NCH_PATCH_TB                              NCH Patch Table
        ------------                              ---------------

                                          invalid '0', '1', '2', '3' or '4' (caused
                                          by erroneous logic in HCFA program code,
                                          which was corrected on 11/1/95).
                                     09 = Zero CWF claim accretion date replaced with
                                          NCH weekly process date (all claim types)
                                          -- applied during Version 'H' conversion to
                                          Instnl and DMERC claims; applied during
                                          Version 'G' conversion to non-institutional
                                          (non-DMERC) claims.  Prior to Version 'H',
                                          patch indicator stored in redefined claim
                                          edit group, 3rd occurrence, position 1.
                                     10 = Multiple Revenue Center 0001 (Outpatient,
                                          HHA and Hospice) -- patch applied to 1998 &
                                          1999 Nearline and SAFs to delete any revenue
                                          codes that followed the first '0001' revenue
                                          center code.   The edit was applied across all
                                          institutional claim types, including Inpatient/
                                          SNF (the problem was only found with OP/HHA/
                                          Hospice claims).  The problem was corrected
                                          6/25/99.
                                     11 = Truncated claim total charge amount in the
                                          fixed portion replaced with the total charge
                                          amount in the revenue center 0001 amount field
                                          -- service years 1998 & 1999 patched during
                                          quarterly merge.  The 1998 & 1999 SAFs were
                                          corrected when finalized in 7/99.  The patch
                                          was done for records with NCH Daily Process
                                          Date 1/4/99 - 5/14/99.
                                     12 = Missing claim-level HHA Total Visit Count --
                                          service years 1998, 1999 & 2000 patch applied
                                          during Version 'I' conversion of both the
                                          Nearline and SAFs.   Problem occurs in those
                                          claims recovered during the missing claims
                                          effort.
                                     13 = Inconsistent Claim MCO Paid Switch made consistent
                                          with criteria used to identify an inpatient
                                          encounter claim -- if MCO paid switch equal to blank
                                          or '0' and ALL conditions are met to indicate an
                                          inpatient encounter claim (bene enrolled in a risk
                                          MCO during the service period), change the switch to
                                          a '1'.  The patch was applied during the Version 'I'
                                          conversion, for claims back to 7/1/97 service thru date.


1       NCH_STATE_SGMT_TB                         NCH State Segment Table
        -----------------                         -----------------------


                                     01 = Alabama
                                     02 = Alaska
                                     03 = Arizona
                                     04 = Arkansas
                                     05 = California
                                     06 = Colorado
                                     07 = Connecticut
```

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                                  08 = Delaware
                                  09 = District of Columbia
                                  10 = Florida
                                  11 = Georgia
                                  12 = Hawaii
                                  13 = Idaho
                                  14 = Illinois
                                  15 = Indiana
                                  16 = Iowa
                                  17 = Kansas
                                  18 = Kentucky
                                  19 = Louisiana
                                  20 = Maine
                                  21 = Maryland
                                  22 = Massachusetts
                                  23 = Michigan
                                  24 = Minnesota
                                  25 = Mississippi
                                  26 = Missouri
                                  27 = Montana
                                  28 = Nebraska
                                  29 = Nevada
                                  30 = New Hampshire
                                  31 = New Jersey
                                  32 = New Mexico
                                  33 = New York
                                  34 = North Carolina
                                  35 = North Dakota
                                  36 = Ohio
                                  37 = Oklahoma
                                  38 = Oregon
                                  39 = Pennsylvania
                                  40 = Puerto Rico
                                  41 = Rhode Island
                                  42 = South Carolina
                                  43 = South Dakota
                                  44 = Tennesee
                                  45 = Texas
                                  46 = Utah
                                  47 = Vermont
                                  48 = Virgin Islands
                                  49 = Virginia
                                  50 = Washington
                                  51 = West Virginia
                                  52 = Wisconsin
                                  53 = Wyoming
                                  54 = Africa
                                  55 = Asia
                                  56 = Canada
                                  57 = Central America & West Indies
1       NCH_STATE_SGMT_TB                        NCH State Segment Table
        -----------------                        -----------------------

                                  58 = Europe
                                  59 = Mexico
                                  60 = Oceania
                                  61 = Philippines
                                  62 = South America
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                      63 = US Possessions
                      97 = Saipan - MP
                      98 = Guam
                      99 = American Samoa


1        PRVDR_NUM_TB                          Provider Number Table
         ------------                          --------------------


         -   First two positions are the GEO SSA State Code.
              Exception: 55 = California
                         67 = Texas
                         68 = Florida

         -   Positions 3 and sometimes 4 are used as a
              category identifier.  The remaining positions
              are serial numbers.  The following blocks of numbers
              are reserved for the facilities indicated (NOTE:
              may have different meanings dependent on the Type
              of Bill (TOB):

             0001-0879   Short-term (general and specialty)
                         hospitals where TOB = 11X; ESRD
                         clinic where TOB = 72X
             0880-0899   Reserved for hospitals participating
                         in ORD demonstration projects where
                         TOB = 11X; ESRD clinic where TOB =
                         72X
             0900-0999   Multiple hospital component in a
                         medical complex (numbers retired)
                         where TOB = 11X; ESRD clinic where
                         TOB = 72X
             1000-1199   Reserved for future use
             1200-1224   Alcohol/drug hospitals (excluded
                         from PPS-numbers retired)
                         where TOB = 11X; ESRD clinic where
                         TOB = 72X
             1225-1299   Medical assistance facilities
                         (Montana project); ESRD clinic where
                         TOB = 72X
             1300-1399   Rural Primary Care Hospital (RCPH) -
                         eff. 10/97 changed to Critical Access
                         Hospitals (CAH)
             1400-1499   Continuation of 4900-4999 series (CMHC)
             1500-1799   Hospices
             1800-1989   Federally Qualified Health Centers
                         (FQHC) where TOB = 73X; SNF (IP PTB)
                         where TOB = 22X; HHA where TOB = 32X,
                         33X, 34X
             1990-1999   Christian Science Sanatoria
                         (hospital services)
             2000-2299   Long-term hospitals (excluded from PPS)
             2300-2499   Chronic renal disease facilities
                         (hospital based)
             2500-2899   Non-hospital renal disease
                         treatment centers
             2900-2999   Independent special purpose renal
                         dialysis facility (1)
```

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             3000-3024   Formerly tuberculosis hospitals
                         (numbers retired)
             3025-3099   Rehabilitation hospitals (excluded
                         from PPS)
             3100-3199   Continuation of Subunits of Nonprofit
                         and Proprietary Home Health Agencies
                         (7300-7399) Series (3) (eff. 4/96)
             3200-3299   Continuation of 4800-4899 series (CORF)
1        PRVDR_NUM_TB              Provider Number Table
         ------------              --------------------

             3300-3399   Children's hospitals (excluded from PPS)
                         where TOB = 11X; ESRD clinic where TOB =
                         72X
             3400-3499   Continuation of rural health clinics
                         (provider-based) (3975-3999)
             3500-3699   Renal disease treatment centers
                         (hospital satellites)
             3700-3799   Hospital based special purpose renal
                         dialysis facility (1)
             3800-3974   Rural health clinics (free-standing)
             3975-3999   Rural health clinics (provider-based)
             4000-4499   Psychiatric hospitals (excluded
                         from PPS)
             4500-4599   Comprehensive Outpatient
                         Rehabilitation Facilities (CORF)
             4600-4799   Community Mental Health Centers (CMHC);
                         9/30/91 - 3/31/97 used for clinic OPT
                         where TOB = 74X
             4800-4899   Continuation of 4500-4599 series (CORF)
                          (eff. 10/95)
             4900-4999   Continuation of 4600-4799 series (CMHC)
                         (eff. 10/95); 9/30/91 - 3/31/97 used for
                         clinic OPT where TOB = 74X
             5000-6499   Skilled Nursing Facilities
             6500-6989   CMHC / Outpatient physical therapy services
                         where TOB = 74X; CORF where TOB =
                         75X
             6990-6999   Christian Science Sanatoria (skilled
                         nursing services)
             7000-7299   Home Health Agencies (HHA) (2)
             7300-7399   Subunits of 'nonprofit' and
                         'proprietary' Home Health Agencies (3)
             7400-7799   Continuation of 7000-7299 series
             7800-7999   Subunits of state and local governmental
                         Home Health Agencies (3)
             8000-8499   Continuation of 7400-7799 series (HHA)
             8500-8899   Continuation of rural health
                         center (provider based) (3400-3499)
             8900-8999   Continuation of rural health
                         center (free-standing) (3800-3974)
             9000-9499   Continuation of 8000-8499 series (HHA)
                         (eff. 10/95)
             9500-9999   Reserved for future use (eff. 8/1/98)
                         NOTE: 10/95-7/98 this series was
                         assigned to HHA's but rescinded - no
                         HHA's were ever assigned a number
                         from this series.
```

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                                     Exception:

                                     P001-P999   Organ procurement organization

                             (1) These facilities (SPRDFS) will be assigned
                                 the same provider number whenever they
                                 are recertified.

                             (2) The 6400-6499 series of provider numbers
                                 in Iowa (16), South Dakota (43) and Texas (45)
1       PRVDR_NUM_TB                              Provider Number Table
        ------------                             ---------------------

                                 have been used in reducing acute care costs (RACC)
                                 experiments.

                             (3) In Virginia (49), the series 7100-7299 has
                                 been reserved for statewide subunit components
                                 of the Virginia state home health agencies.

                             (4) Parent agency must have a number in the
                                 7000-7299, 7400-7799 or 8000-8499 series.

                             NOTE:
                               There is a special numbering system for units
                               of hospitals that are excluded from prospective
                               payment system (PPS) and hospitals with SNF
                               swing-bed designation.  An alpha character in
                               the third position of the provider number
                               identifies the type of unit or swing-bed
                               designation as follows:

                                 S = Psychiatric unit (excluded from PPS)
                                 T = Rehabilitation unit (excluded from PPS)
                                 U = Short term/acute care swing-bed hospital
                                 V = Alcohol drug unit (prior to 10/87 only)
                                 W = Long term SNF swing-bed hospital
                                     (eff 3/91)
                                 Y = Rehab hospital swing-bed (eff 9/92)
                                 Z = Rural primary care swing-bed hospital

                               There is also a special numbering system for
                               assigning emergency hospital identification
                               numbers (non participating hospitals).  The
                               sixth position of the provider number is as
                               follows:

                                 E = Non-federal emergency hospital
                                 F = Federal emergency hospital

1       PTNT_DSCHRG_STUS_TB                      Patient Discharge Status Table
        -------------------                      -----------------------------

                             01 = Discharged to home/self care (routine
                                  charge).
                             02 = Discharged/transferred to other short term
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                general hospital for inpatient care.
    03 = Discharged/transferred to skilled
         nursing facility (SNF) - (For hospitals
         with an approved swing bed arrangement,
         use Code 61 - swing bed.  For reporting
         discharges/transfers to a non-certified
         SNF, the hospital must use Code 04 - ICF.
    04 = Discharged/transferred to intermediate
         care facility (ICF).
    05 = Discharged/transferred to another type
         of institution for inpatient care (including
         distinct parts).
    06 = Discharged/transferred to home care of
         organized home health service organization.
    07 = Left against medical advice or discontinued
         care.
    08 = Discharged/transferred to home under
         care of a home IV drug therapy provider.
    09 = Admitted as an inpatient to this
         hospital (effective 3/1/91).  In situa-
         tions  where a patient is admitted before
         midnight of the third day following the
         day of an outpatient service, the out-
         patient services are considered inpatient.
    20 = Expired (did not recover - Christian
         Science patient).
    30 = Still patient.
    40 = Expired at home (hospice claims only)
    41 = Expired in a medical facility such as
         hospital, SNF, ICF, or freestanding
         hospice. (Hospice claims only)
    42 = Expired - place unknown (Hospice claims
         only)
    50 = Hospice - home (eff. 10/96)
    51 = Hospice - medical facility (eff. 10/96)
    61 = Discharged/transferred within this insti-
         tution to a hospital-based Medicare
         approved swing bed (to be implemented in
         1999)
    71 = Discharged/transferred/referred to another
         institution for outpatient services as
         specified by the discharge plan of care (to
         be implemented in 1999).
    72 = Discharged/transferred/referred to this
         institution for outpatient services as
         specified by the discharge plan of care
         (to be implemented in 1999).
```

1   REV_CNTR_ANSI_TB   Revenue Center ANSI Code Table
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```
        *******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
        **************POSITIONS 1 & 2 OF ANSI CODE**************
        CO = Contractual Obligations -- this group code should
             be used when a contractual agreement between the
             payer and payee, or a regulatory requirement, re-
             sulted in an adjustment.  Generally, these adjust-
```

ments are considered a write-off for the provider
        and are not billed to the patient.

   CR = Corrections and Reversals -- this group code should
        be used for correcting a prior claim. It applies
        when there is a change to a previously adjudicated
        claim.

   OA = Other Adjustments -- this group code should be used
        when no other group code applies to the adjustment.

   PI = Payer Initiated Reductions -- this group code should
        be used when, in the opinion of the payer, the adjust-
        ment is not the responsibility of the patient, but
        there is no supporting contract between the provider
        and the payer (i.e., medical review or professional
        review organization adjustments).

   PR = Patient Responsibility -- this group should be used
        when the adjustment represents an amount that should
        be billed to the patient or insured. This group
        would typically be used for deductible and copay
        adjustments.

   ***********Claim Adjustment Reason Codes***************
   ***********POSITIONS 3 through 5 of ANSI CODE**********

   1 = Deductible Amount
   2 = Coinsurance Amount
   3 = Co-pay Amount
   4 = The procedure code is inconsistent with the modifier
       used or a required modifier is missing.
   5 = The procedure code/bill type is inconsistent with the
       place of service.
   6 = The procedure code is inconsistent with the patient's
       age.
   7 = The procedure code is inconsistent with the patient's
       gender.
   8 = The procedure code is inconsistent with the provider
       type.
   9 = The diagnosis is inconsistent with the patient's age.
   10 = The diagnosis is inconsistent with the patient's
        gender.
   11 = The diagnosis is inconsistent with the procedure.
   12 = The diagnosis is inconsistent with the provider type.
   13 = the date of death precedes the date of service.
   14 = The date of birth follows the date of service.
   15 = Claim/service adjusted because the submitted auth-
        orization number is missing, invalid, or does not
        apply to the billed services or provider.
   16 = Claim/service lacks information which is needed for

1   REV_CNTR_ANSI_TB   Revenue Center ANSI Code Table
       ----------------   ----------------------------

        adjudication.
   17 = Claim/service adjusted because requested information
        was not provided or was insufficient/incomplete.
   18 = Duplicate claim/service.

```
19 = Claim denied because this is a work-related injury/
     illness and thus the liability of the Worker's Com-
     pensation Carrier.
20 = Claim denied because this injury/illness is covered
     by the liability carrier.
21 = Claim denied because this injury/illness is the
     liability of the no-fault carrier.
22 = Claim adjusted because this care may be covered by
     another payer per coordination of benefits.
23 = Claim adjusted because charges have been paid by
     another payer.
24 = Payment for charges adjusted.  Charges are covered
     under a capitation agreement/managed care plan.
25 = Payment denied.  Your Stop loss deductible has not
     been met.
26 = Expenses incurred prior to coverage.
27 = Expenses incurred after coverage terminated.
28 = Coverage not in effect at the time the service was
     provided.
29 = The time limit for filing has expired.
30 = Claim/service adjusted because the patient has not met
     the required eligibility, spend down, waiting, or
     residency requirements.
31 = Claim denied as patient cannot be identified as our
     insured.
32 = Our records indicate that this dependent is not an
     eligible dependent as defined.
33 = Claim denied.  Insured has no dependent coverage.
34 = Claim denied.  Insured has no coverage for newborns.
35 = Benefit maximum has been reached.
36 = Balance does not exceed copayment amount.
37 = Balance does not exceed deductible amount.
38 = Services not provided or authorized by designated
     (network) providers.
39 = Services denied at the time authorization/pre-certi-
     fication was requested.
40 = Charges do not meet qualifications for emergency/urgent
     care.
41 = Discount agreed to in Preferred Provider contract.
42 = Charges exceed our fee schedule or maximum allowable
     amount.
43 = Gramm-Rudman reduction.
44 = Prompt-pay discount.
45 = Charges exceed your contracted/legislated fee arrange-
     ment.
46 = This (these) service(s) is(are) not covered.
47 = This (these) diagnosis(es) is(are) not covered,
     missing, or are invalid.
48 = This (these) procedure(s) is(are) not covered.
49 = These are non-covered services because this is a
     routine exam or screening procedure done in conjunc-
     tion with a routine exam.
50 = These are non-covered services because this is not
     deemed a 'medical necessity' by the payer.
```

1   REV_CNTR_ANSI_TB   Revenue Center ANSI Code Table
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51 = These are non-covered services because this a pre-
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        existing condition.
52 = The referring/prescribing/rendering provider is not
     eligible to refer/prescribe/order/perform the service
     billed.
53 = Services by an immediate relative or a member of the
     same household are not covered.
54 = Multiple physicians/assistants are not covered in this
     case.
55 = Claim/service denied because procedure/treatment is
     deemed experimental/investigational by the payer.
56 = Claim/service denied because procedure/treatment has
     not been deemed 'proven to be effective' by payer.
57 = Claim/service adjusted because the payer deems the
     information submitted does not support this level of
     service, this many services, this length of service, or
     this dosage.
58 = Claim/service adjusted because treatment was deemed by
     the payer to have been rendered in an inappropriate
     or invalid place of service.
59 = Charges are adjusted based on multiple surgery rules or
     concurrent anesthesia rules.
60 = Charges for outpatient services with the proximity to
     inpatient services are not covered.
61 = Charges adjusted as penalty for failure to obtain second
     surgical opinion.
62 = Claim/service denied/reduced for absence of, or exceeded,
     precertification/authorization.
63 = Correction to a prior claim. INACTIVE
64 = Denial reversed per Medical Review. INACTIVE
65 = Procedure code was incorrect.  This payment reflects the
     correct code. INACTIVE
66 = Blood Deductible.
67 = Lifetime reserve days. INACTIVE
68 = DRG weight. INACTIVE
69 = Day outlier amount.
70 = Cost outlier amount.
71 = Primary Payer amount.
72 = Coinsurance day. INACTIVE
73 = Administrative days. INACTIVE
74 = Indirect Medical Education Adjustment.
75 = Direct Medical Education Adjustment.
76 = Disproportionate Share Adjustment.
77 = Covered days. INACTIVE
78 = Non-covered days/room charge adjustment.
79 = Cost report days. INACTIVE
80 = Outlier days. INACTIVE
81 = Discharges. INACTIVE
82 = PIP days. INACTIVE
83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE
87 = Transfer amounts.
88 = Adjustment amount represents collection against
     receivable created in prior overpayment.
89 = Professional fees removed from charges.
90 = Ingredient cost adjustment.
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        91 = Dispensing fee adjustment.
        92 = Claim paid in full. INACTIVE
        93 = No claim level adjustment. INACTIVE
        94 = Process in excess of charges.
        95 = Benefits adjusted.  Plan procedures not followed.
        96 = Non-covered charges.
        97 = Payment is included in allowance for another
             service/procedure.
        98 = The hospital must file the Medicare claim for this
             inpatient non-physician service. INACTIVE
        99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
       100 = Payment made to patient/insured/responsible party.
       101 = Predetermination: anticipated payment upon comple-
             tion of services or claim ajudication.
       102 = Major medical adjustment.
       103 = Provider promotional discount (i.e. Senior citizen
             discount).
       104 = Managed care withholding.
       105 = Tax withholding.
       106 = Patient payment option/election not in effect.
       107 = Claim/service denied because the related or qualifying
             claim/service was not paid or identified on the claim.
       108 = Claim/service reduced because rent/purchase guidelines
             were not met.
       109 = Claim not covered by this payer/contractor.  You must
             send the claim to the correct payer/contractor.
       110 = Billing date predates service date.
       111 = Not covered unless the provider accepts assignment.
       112 = Claim/service adjusted as not furnished directly
             to the patient and/or not documented.
       113 = Claim denied because service/procedure was provided
             outside the United States or as a result of war.
       114 = Procedure/product not approved by the Food and Drug
             Administration.
       115 = Claim/service adjusted as procedure postponed or
             canceled.
       116 = Claim/service denied.  The advance indemnification
             notice signed by the patient did not comply with
             requirements.
       117 = Claim/service adjusted because transportation is only
             covered to the closest facility that can provide
             the necessary care.
       118 = Charges reduced for ESRD network support.
       119 = Benefit maximum for this time period has been reached.
       120 = Patient is covered by a managed care plan. INACTIVE
       121 = Indemnification adjustment.
       122 = Psychiatric reduction.
       123 = Payer refund due to overpayment.  INACTIVE
       124 = Payer refund amount - not our patient. INACTIVE
       125 = Claim/service adjusted due to a submission/billing
             error(s).
       126 = Deductible - Major Medical.
       127 = Coinsurance - Major Medical.
       128 = Newborn's services are covered in the mother's
             allowance.
       129 = Claim denied - prior processing information appears
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                                        incorrect.
                           130 = Paper claim submission fee.
1      REV_CNTR_ANSI_TB                        Revenue Center ANSI Code Table
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                           131 = Claim specific negotiated discount.
                           132 = Prearranged demonstration project adjustment.
                           133 = The disposition of this claim/service is pending
                                 further review.
                           134 = Technical fees removed from charges.
                           135 = Claim denied.  Interim bills cannot be processed.
                           136 = Claim adjusted.  Plan procedures of a prior payer
                                 were not followed.
                           137 = Payment/Reduction for Regulatory Surcharges, Assess-
                                 ments, Allowances or Health Related Taxes.
                           138 = Claim/service denied.  Appeal procedures not
                                 followed or time limits not met.
                           139 = Contracted funding agreement - subscriber is employed
                                 by the provider of services.
                           140 = Patient/Insured health identification number and name
                                 do not match.
                           141 = Claim adjustment because the claim spans eligible
                                 and ineligible periods of coverage.
                           142 = Claim adjusted by the monthly Medicaid patient
                                 liability amount.
                           A0 = Patient refund amount
                           A1 = Claim denied charges.
                           A2 = Contractual adjustment.
                           A3 = Medicare Secondary Payer liability met. INACTIVE
                           A4 = Medicare Claim PPS Capital Day Outlier Amount.
                           A5 = Medicare Claim PPS Capital Cost Outlier Amount.
                           A6 = Prior hospitalization or 30 day transfer requirement
                                not met.
                           A7 = Presumptive Payment Adjustment.
                           A8 = Claim denied; ungroupable DRG.
                           B1 = Non-covered visits.
                           B2 = Covered visits. INACTIVE
                           B3 = Covered charges. INACTIVE
                           B4 = Late filing penalty.
                           B5 = Claim/service adjusted because coverage/program
                                guidelines were not met or were exceeded.
                           B6 = This service/procedure is adjusted when performed/
                                billed by this type of provider, by this type of
                                facility, or by a provider of this specialty.
                           B7 = This provider was not certified/eligible to be
                                paid for this procedure/service on this date of
                                service.
                           B8 = Claim/service not covered/reduced because alter-
                                native services were available, and should have
                                been utilized.
                           B9 = Services not covered because the patient is en-
                                rolled in a Hospice.
                           B10 = Allowed amount has been reduced because a com-
                                 ponent of the basic procedure/test was paid.  The
                                 beneficiary is not liable for more than the charge
                                 limit for the basic procedure/test.
                           B11 = The claim/service has been transferred to the
                                 proper payer/processor for processing.  Claim/
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                              service not covered by this payer/processor.
                    B12 = Services not documented in patients' medical re-
                              cords.
                    B13 = Previously paid.  Payment for this claim/service
                              may have been provided in a previous payment.
1       REV_CNTR_ANSI_TB                     Revenue Center ANSI Code Table
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                    B14 = Claim/service denied because only one visit or
                              consultation per physician per day is covered.
                    B15 = Claim/service adjusted because this procedure/
                              service is not paid separately.
                    B16 = Claim/service adjusted because 'New Patient'
                              qualifications were not met.
                    B17 = Claim/service adjusted because this service was
                              not prescribed by a physician, not prescribed
                              prior to delivery, the prescription is incomplete,
                              or the prescription is not current.
                    B18 = Claim/service denied because this procedure code/
                              modifier was invalid on the date of service or
                              claim submission.
                    B19 = Claim/service adjusted because of the finding of a
                              Review Organization.  INACTIVE
                    B20 = Charges adjusted because procedure/service was
                              partially or fully furnished by another provider.
                    B21 = The charges were reduced because the service/care
                              was partially furnished by another physician.
                              INACTIVE
                    B22 = This claim/service is adjusted based on the
                              diagnosis.
                    B23 = Claim/service denied because this provider has
                              failed an aspect of a proficiency testing program.
                    W1 = Workers Compensation State Fee Schedule Adjustment.

1       REV_CNTR_APC_TB                 Revenue Center Ambulatory Payment Classification (APC)
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                    0001 = Photochemotherapy
                    0002 = Fine needle Biopsy/Aspiration
                    0003 = Bone Marrow Biopsy/Aspiration
                    0004 = Level I Needle Biopsy/ Aspiration Except
                              Bone Marrow
                    0005 = Level II Needle Biopsy /Aspiration Except
                              Bone Marrow
                    0006 = Level I Incision & Drainage
                    0007 = Level II Incision & Drainage
                    0008 = Level III Incision & Drainage
                    0009 = Nail Procedures
                    0010 = Level I Destruction of Lesion
                    0011 = Level II Destruction of Lesion
                    0012 = Level I Debridement & Destruction
                    0013 = Level II Debridement & Destruction
                    0014 = Level III Debridement & Destruction
                    0015 = Level IV Debridement & Destruction
                    0016 = Level V Debridement & Destruction
                    0017 = Level VI Debridement & Destruction
                    0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
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                       0019 = Level I Excision/ Biopsy
                       0020 = Level II Excision/ Biopsy
                       0021 = Level III Excision/ Biopsy
                       0022 = Level IV Excision/ Biopsy
                       0023 = Exploration Penetrating Wound
                       0024 = Level I Skin Repair
                       0025 = Level II Skin Repair
                       0026 = Level III Skin Repair
                       0027 = Level IV Skin Repair
                       0029 = Incision/Excision Breast
                       0030 = Breast Reconstruction/Mastectomy
                       0031 = Hyperbaric Oxygen
                       0032 = Placement Transvenous Catheters/Arterial Cutdown
                       0033 = Partial Hospitalization
                       0040 = Arthrocentesis & Ligament/Tendon Injection
                       0041 = Arthroscopy
                       0042 = Arthroscopically-Aided Procedures
                       0043 = Closed Treatment Fracture Finger/Toe/Trunk
                       0044 = Closed Treatment Fracture/Dislocation Except
                              Finger/Toe/Trunk
                       0045 = Bone/Joint Manipulation Under Anesthesia
                       0046 = Open/Percutaneous Treatment Fracture or Dislocation
                       0047 = Arthroplasty without Prosthesis
                       0048 = Arthroplasty with Prosthesis
                       0049 = Level I Musculoskeletal Procedures Except Hand
                              and Foot
                       0050 = Level II Musculoskeletal Procedures Except Hand
                              and Foot
                       0051 = Level III Musculoskeletal Procedures Except Hand
                              and Foot
                       0052 = Level IV Musculoskeletal Procedures Except Hand
                              and Foot
                       0053 = Level I Hand Musculoskeletal Procedures
                       0054 = Level II Hand Musculoskeletal Procedures
                       0055 = Level I Foot Musculoskeletal Procedures
                       0056 = Level II Foot Musculoskeletal Procedures
                       0057 = Bunion Procedures
1       REV_CNTR_APC_TB            Revenue Center Ambulatory Payment Classification (APC)
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                       0058 = Level I Strapping and Cast Application
                       0059 = Level II Strapping and Cast Application
                       0060 = Manipulation Therapy
                       0070 = Thoracentesis/Lavage Procedures
                       0071 = Level I Endoscopy Upper Airway
                       0072 = Level II Endoscopy Upper Airway
                       0073 = Level III Endoscopy Upper Airway
                       0074 = Level IV Endoscopy Upper Airway
                       0075 = Level V Endoscopy Upper Airway
                       0076 = Endoscopy Lower Airway
                       0077 = Level I Pulmonary Treatment
                       0078 = Level II Pulmonary Treatment
                       0079 = Ventilation Initiation and Management
                       0080 = Diagnostic Cardiac Catheterization
                       0081 = Non-Coronary Angioplasty or Atherectomy
                       0082 = Coronary Atherectomy
                       0083 = Coronary Angiosplasty
                       0084 = Level I Electrophysiologic Evaluation
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                          0085 = Level II Electrophysiologic Evaluation
                          0086 = Ablate Heart Dysrhythm Focus
                          0087 = Cardiac Electrophysiologic Recording/Mapping
                          0088 = Thrombectomy
                          0089 = Level I Implantation/Removal/Revision of Pacemaker,
                                 AICD Vascular Device
                          0090 = Level II Implantation/Removal/Revision of Pacemaker,
                                 AICD Vascular Device
                          0091 = Level I Vascular Ligation
                          0092 = Level II Vascular Ligation
                          0093 = Vascular Repair/Fistula Construction
                          0094 = Resuscitation and Cardioversion
                          0095 = Cardiac Rehabilitation
                          0096 = Non-Invasive Vascular Studies
                          0097 = Cardiovascular Stress Test
                          0098 = Injection of Sclerosing Solution
                          0099 = Continuous Cardiac Monitoring
                          0100 = Continuous ECG
                          0101 = Tilt Table Evaluation
                          0102 = Electronic Analysis of Pacemakers/other Devices
                          0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell
                                 Transplant
                          0110 = Transfusion
                          0111 = Blood Product Exchange
                          0112 = Extracorporeal Photopheresis
                          0113 = Excision Lymphatic System
                          0114 = Thyroid/Lymphadenectomy Procedures
                          0116 = Chemotherapy Administration by Other Technique
                                 Except Infusion
                          0117 = Chemotherapy Administration by Infusion Only
                          0118 = Chemotherapy Administration by Both Infusion and
                                 Other Technique
                          0120 = Infusion Therapy Except Chemotherapy
                          0121 = Level I Tube changes and Repositioning
                          0122 = Level II Tube changes and Repositioning
                          0123 = Level III Tube changes and Repositioning
                          0130 = Level I Laparoscopy
                          0131 = Level II Laparoscopy
                          0132 = Level III Laparoscopy
                          0140 = Esophageal Dilation without Endoscopy
1        REV_CNTR_APC_TB            Revenue Center Ambulatory Payment Classification (APC)
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                          0141 = Upper GI Procedures
                          0142 = Small Intestine Endoscopy
                          0143 = Lower GI Endoscopy
                          0144 = Diagnostic Anoscopy
                          0145 = Therapeutic Anoscopy
                          0146 = Level I Sigmoidoscopy
                          0147 = Level II Sigmoidoscopy
                          0148 = Level I Anal/Rectal Procedure
                          0149 = Level II Anal/Rectal Procedure
                          0150 = Level III Anal/Rectal Procedure
                          0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
                          0152 = Percutaneous Biliary Endoscopic Procedures
                          0153 = Peritoneal and Abdominal Procedures
                          0154 = Hernia/Hydrocele Procedures
                          0157 = Colorectal Cancer Screening: Barium Enema
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                         (Not subject to National coinsurance)
            0158 = Colorectal Cancer Screening: Colonoscopy
                         Not subject to National coinsurance.  Minimum
                         unadjusted coinsurance is 25% of the payment rate.
                         Payment rate is lower of the HOPD payment rate or
                         the Ambulatory Surgical Center payment.
            0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy
                         Not subject to National coinsurance.  Minimum
                         unadjusted coinsurance is 25% of the payment rate.
                         Payment rate is lower of the HOPD payment rate or
                         the Ambulatory Surgical Center payment.
            0160 = Level I Cystourethroscopy and other Genitourinary
                         Procedures
            0161 = Level II Cystourethroscopy and other Genitourinary
                         Procedures
            0162 = Level III Cystourethroscopy and other Genitourinary
                         Procedures
            0163 = Level IV Cystourethroscopy and other Genitourinary
                         Procedures
            0164 = Level I  Urinary and Anal Procedures
            0165 = Level II  Urinary and Anal Procedures
            0166 = Level I Urethral Procedures
            0167 = Level II Urethral Procedures
            0168 = Level III Urethral Procedures
            0169 = Lithotripsy
            0170 = Dialysis for Other Than ESRD Patients
            0180 = Circumcision
            0181 = Penile Procedures
            0182 = Insertion of Penile Prosthesis
            0183 = Testes/Epididymis Procedures
            0184 = Prostate Biopsy
            0190 = Surgical Hysteroscopy
            0191 = Level I Female Reproductive Procedures
            0192 = Level II Female Reproductive Procedures
            0193 = Level III Female Reproductive Procedures
            0194 = Level IV Female Reproductive Procedures
            0195 = Level V Female Reproductive Procedures
            0196 = Dilatation & Curettage
            0197 = Infertility Procedures
            0198 = Pregnancy and Neonatal Care Procedures
            0199 = Vaginal Delivery
            0200 = Therapeutic Abortion
            0201 = Spontaneous Abortion
1       REV_CNTR_APC_TB         Revenue Center Ambulatory Payment Classification (APC)
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            0210 = Spinal Tap
            0211 = Level I Nervous System Injections
            0212 = Level II Nervous System Injections
            0213 = Extended EEG Studies and Sleep Studies
            0214 = Electroencephalogram
            0215 = Level I Nerve and Muscle Tests
            0216 = Level II Nerve and Muscle Tests
            0217 = Level III Nerve and Muscle Tests
            0220 = Level I Nerve Procedures
            0221 = Level II Nerve Procedures
            0222 = Implantation of Neurological Device
            0223 = Level I Revision/Removal Neurological Device
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                              0224 = Level II Revision/Removal Neurological Device
                              0225 = Implantation of Neurostimulator Electrodes
                              0230 = Level I Eye Tests
                              0231 = Level II Eye Tests
                              0232 = Level I Anterior Segment Eye
                              0233 = Level II Anterior Segment Eye
                              0234 = Level III Anterior Segment Eye Procedures
                              0235 = Level I Posterior Segment Eye Procedures
                              0236 = Level II Posterior Segment Eye Procedures
                              0237 = Level III Posterior Segment Eye Procedures
                              0238 = Level I Repair and Plastic Eye Procedures
                              0239 = Level II Repair and Plastic Eye Procedures
                              0240 = Level III Repair and Plastic Eye Procedures
                              0241 = Level IV Repair and Plastic Eye Procedures
                              0242 = Level V Repair and Plastic Eye Procedures
                              0243 = Strabismus/Muscle Procedures
                              0244 = Corneal Transplant
                              0245 = Cataract Procedures without IOL Insert
                              0246 = Cataract Procedures with IOL Insert
                              0247 = Laser Eye Procedures Except Retinal
                              0248 = Laser Retinal Procedures
                              0250 = Nasal Cauterization/Packing
                              0251 = Level I ENT Procedures
                              0252 = Level II ENT Procedures
                              0253 = Level III ENT Procedures
                              0254 = Level IV ENT Procedures
                              0256 = Level V ENT Procedures
                              0257 = Implantation of Cochlear Device
                              0258 = Tonsil and Adenoid Procedures
                              0260 = Level I Plain Film Except Teeth
                              0261 = Level II Plain Film Except Teeth Including Bone
                                     Density Measurement
                              0262 = Plain Film of Teeth
                              0263 = Level I Miscellaneous Radiology Procedures
                              0264 = Level II Miscellaneous Radiology Procedures
                              0265 = Level I Diagnostic Ultrasound Except Vascular
                              0266 = Level II Diagnostic Ultrasound Except Vascular
                              0267 = Vascular Ultrasound
                              0268 = Guidance Under Ultrasound
                              0269 = Echocardiogram Except Transesophageal
                              0270 = Transesophageal Echocardiogram
                              0271 = Mammography
                              0272 = Level I Fluoroscopy
                              0273 = Level II Fluoroscopy
                              0274 = Myelography
                              0275 = Arthrography
1       REV_CNTR_APC_TB                 Revenue Center Ambulatory Payment Classification (APC)
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                              0276 = Level I Digestive Radiology
                              0277 = Level II Digestive Radiology
                              0278 = Diagnostic Urography
                              0279 = Level I Diagnostic Angiography and Venography
                                     Except Extremity
                              0280 = Level II Diagnostic Angiography and Venography
                                     Except Extremity
                              0281 = Venography of Extremity
                              0282 = Level I Computerized Axial Tomography
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                    0283 = Level II Computerized Axial Tomography
                    0284 = Magnetic Resonance Imaging
                    0285 = Positron Emission Tomography (PET)
                    0286 = Myocardial Scans
                    0290 = Standard Non-Imaging Nuclear Medicine
                    0291 = Level I Diagnostic Nuclear Medicine Excluding
                           Myocardial Scans
                    0292 = Level II Diagnostic Nuclear Medicine Excluding
                           Myocardial Scans
                    0294 = Level I Therapeutic Nuclear Medicine
                    0295 = Level II Therapeutic Nuclear Medicine
                    0296 = Level I Therapeutic Radiologic Procedures
                    0297 = Level II Therapeutic Radiologic Procedures
                    0300 = Level I Radiation Therapy
                    0301 = Level II Radiation Therapy
                    0302 = Level III Radiation Therapy
                    0303 = Treatment Device Construction
                    0304 = Level  I Therapeutic Radiation Treatment
                           Preparation
                    0305 = Level II Therapeutic Radiation Treatment
                           Preparation
                    0310 = Level III Therapeutic Radiation Treatment
                           Preparation
                    0311 = Radiation Physics Services
                    0312 = Radioelement Applications
                    0313 = Brachytherapy
                    0314 = Hyperthermic Therapies
                    0320 = Electroconvulsive Therapy
                    0321 = Biofeedback and Other Training
                    0322 = Brief Individual Psychotherapy
                    0323 = Extended Individual Psychotherapy
                    0324 = Family Psychotherapy
                    0325 = Group Psychotherapy
                    0330 = Dental Procedures
                    0340 = Minor Ancillary Procedures
                    0341 = Immunology Tests
                    0342 = Level I Pathology
                    0343 = Level II Pathology
                    0344 = Level III Pathology
                    0354 = Administration of Influenza Vaccine (Not
                           subject to national coinsurance)
                    0355 = Level I Immunizations
                    0356 = Level II Immunizations
                    0357 = Level III Immunizations
                    0358 = Level IV Immunizations
                    0359 = Injections
                    0360 = Level I Alimentary Tests
                    0361 = Level II Alimentary Tests
                    0362 = Fitting of Vision Aids
1      REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
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                    0363 = Otorhinolaryngologic Function Tests
                    0364 = Level I Audiometry
                    0365 = Level II Audiometry
                    0366 = Electrocardiogram (ECG)
                    0367 = Level I Pulmonary Test
                    0368 = Level II Pulmonary Test
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                    0369 = Level III Pulmonary Test
                    0370 = Allergy Tests
                    0371 = Allergy Injections
                    0372 = Therapeutic Phlebotomy
                    0373 = Neuropsychological Testing
                    0374 = Monitoring Psychiatric Drugs
                    0600 = Low Level Clinic Visits
                    0601 = Mid Level Clinic Visits
                    0602 = High Level Clinic Visits
                    0603 = Interdisciplinary Team Conference
                    0610 = Low Level Emergency Visits
                    0611 = Mid Level Emergency Visits
                    0612 = High Level Emergency Visits
                    0620 = Critical Care
                    0701 = Strontium (eligible for pass-through payments)
                    0702 = Samariam (eligible for pass-through payments)
                    0704 = Satumomab Pendetide (eligible for pass-through
                           payments)
                    0705 = Tc99 Tetrofosmin (eligible for pass-through
                           payments)
                    0725 = Leucovorin Calcium (eligible for pass-through
                           payments)
                    0726 = Dexrazoxane Hydrochloride (eligible for pass-)
                           through payments)
                    0727 = Injection, Etidronate Disodium (eligible for
                           pass-through payments)
                    0728 = Filgrastim (G-CSF) (eligible for pass-through
                           payments)
                    0730 = Pamidronate Disodium (eligible for pass-through
                           payments)
                    0731 = Sargramostim (GM-CSF) (eligible for pass-through
                           payments)
                    0732 = Mesna (eligible for pass-through payments)
                    0733 = Epoetin Alpha (eligible for pass-through)
                           payments)
                    0750 = Dolasetron Mesylate 10 mg (eligible for pass-
                           through payments)
                    0754 = Metoclopramide HCL (eligible for pass-through
                           payments)
                    0755 = Thiethylperazine Maleate (eligible for pass-through
                           payments)
                    0761 = Oral Substitute for IV Antiemtic (eligible for pass-
                           through payments)
                    0762 = Dronabinol (elibible for pass-through payments)
                    0763 = Dolasetron Mesylate 100 mg Oral (eligible for
                           pass-through payments)
                    0764 = Granisetron HCL, 100 mcg (eligible for pass-
                           through payments)
                    0765 = Granisetron HCL, 1mg Oral (eligible for pass-
                           through payments)
                    0768 = Ondansetron Hydrochloride per 1 mg Injection
                           (eligible for pass-through payments)
1       REV_CNTR_APC_TB                 Revenue Center Ambulatory Payment Classification (APC)
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                    0769 = Ondansetron Hydrochloride 8 mg oral
                           (eligible for pass-through payments)
                    0800 = Leuprolide Acetate per 3.75 mg (eligible for
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                      pass-through payments)
        0801 = Cyclophosphamide (eligible for pass-through
               payments)
        0802 = Etoposide (eligible for pass-through payments)
        0803 = Melphalan (eligible for pass-through payments)
        0807 = Aldesleukin single use vial (eligible for pass-
               through payments)
        0809 = BCG (Intravesical) one vial (eligible for pass-
               through payments)
        0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for
               pass-through payments)
        0811 = Carboplatin 50 mg (eligible for pass-through
               payments)
        0812 = Carmustine 100 mg (eligible for pass-through
               payments)
        0813 = Cisplatin 10 mg (eligible for pass-through
               payments)
        0814 = Asparaginase, 10,000 units (eligible for pass-
               through payments)
        0815 = Cyclophosphamide 100 mg (eligible for pass-
               through payments)
        0816 = Cyclophosphamide, Lyophilized 100 mg (eligible
               for pass-through payments)
        0817 = Cytrabine 100 mg (eligible for pass-through
               payments)
        0818 = Dactinomycin 0.5 mg (eligible for pass-through
               payments)
        0819 = Dacarbazine 100 mg (eligible for pass-through
               payments)
        0820 = Daunorubicin HCI 10 mg (eligible for pass-through
               payments)
        0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg
               (eligible for pass-through payments)
        0822 = Diethylstibestrol Diphosphate 250 mg
               (eligible for pass-through payments)
        0823 = Docetaxel 20 mg (eligible for pass-through
               payments)
        0824 = Etoposide 10 mg (eligible for pass-through
               payments)
        0826 = Methotrexate Oral 2.5 mg (eligible for pass-through
               payments)
        0827 = Floxuridine 500 mg (eligible for pass-through
               payments)
        0828 = Gemcitabine HCL 200 mg (eligibile for pass-
               through payments)
        0830 = Irinotecan 20 mg (eligible for pass-through
               payments)
        0831 = Ifosfamide per 1 gram (eligible for pass-through
               payments)
        0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-
               through payments)
        0833 = Interferon Alfacon-1, Recombinant, 1 mcg
               (eligible for pass-through payments)
        0834 = Interferon,  Alfa-2A, Recombinant 3 million units
               (eligible for pass-through payments)
1       REV_CNTR_APC_TB                Revenue Center Ambulatory Payment Classification (APC)
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0836 = Interferon,  Alfa-2B, Recombinant, 1 million units
       (eligible for pass-through payments)
0838 = Interferon, Gamma 1-B, 3 million units
       (eligible for pass-through payments)
0839 = Mechlorethamine HCI 10 mg
       (eligible for pass-through payments)
0840 = Melphalan HCI 50 mg (eligible for pass-
       through payments)
0841 = Methotrexate Sodium 5 mg (eligible for pass-
       through payments)
0842 = Fludarabine Phosphate 50 mg (eligible for pass-
       through payments)
0843 = Pegaspargase per single dose vial (eligible for
       pass-through payments)
0844 = Pentostatin 10 mg (eligible for pass-through
       payments)
0847 = Doxorubicin HCL 10 mg (eligible for pass-through
       payments)
0849 = Rituximab, 100 mg (eligible for pass-through
       payments)
0850 = Streptozocin 1 gm (eligible for pass-through
       payments)
0851 = Thiotepa 15 mg (eligible for pass-through pay-
       ments)
0852 = Topotecan 4 mg (eligible for pass-through payments)
0853 = Vinblastine Sulfate 1 mg (eligible for pass-through
       payments)
0854 = Vincristine Sulfate 1 mg (eligible for pass-through
       payments)
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-
       through payments)
0856 = Porfimer Sodium 75 mg (eligible for pass-through
       payments)
0857 = Bleomycin Sulfate 15 units (eligible for pass-through
       payments)
0858 = Cladribine, 1mg (eligible for pass-through payments)
0859 = Fluorouracil (eligible for pass-through payments)
0860 = Plicamycin 2.5 mg (eligible for pass-through payments)
0861 = Leuprolide Acetate 1 mg (eligible for pass-through
       payments)
0862 = Mitomycin, 5mg (eligible for pass-through payments)
0863 = Paclitaxel, 30mg (eligible for pass-through payments)
0864 = Mitoxantrone HCl,  per 5mg (eligible for pass-through
       payments)
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-
       through payments)
0884 = Rho (D) Immune Globulin, Human one dose pack
       (eligible for pass-through payments)
0886 = Azathioprine,  50 mg oral
       (Not subject to national coinsurance)
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection
       (Not subject to national coinsurance)
0888 = Cyclosporine, Oral 100 mg
       (Not subject to national coinsurance)
0889 = Cyclosporine, Parenteral
       (Not subject to national coinsurance)
0890 = Lymphocyte Immune Globulin 50 mg/ ml, 5 ml each
       (Not subject to national coinsurance)
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               0891 = Tacrolimus per 1 mg oral
                        (Not subject to national coinsurance)
               0892 = Daclizumab, Parenteral, 25 mg
                        (eligible for pass-through payments)
               0900 = Injection, Alglucerase per 10 units
                        (eligible for pass-through payments)
               0901 = Alpha I, Proteinase Inhibitor, Human per 10mg
                        (eligible for pass-through payments)
               0902 = Botulinum Toxin, Type A per unit
                        (eligible for pass-through payments)
               0903 = CMV Immune Globulin
                        (eligible for pass-through payments)
               0905 = Immune Globulin per 500 mg
                        (eligible for pass-through payments)
               0906 = RSV Immune Globulin
                        (eligible for pass-through payments)
               0907 = Ganciclovir Sodium 500 mg injection
                        (Not subject to national coinsurance)
               0908 = Tetanus Immune Globulin, Human, up to 250 units
                        (Not subject to national coinsurance)
               0909 = Interferon Beta - 1a   33 mcg (eligible for pass-
                        through payments)
               0910 = Interferon Beta - 1b   0.25 mg (eligible for pass-
                        through payments)
               0911 = Streptokinase per 250,000 iu
                        (Not subject to national coinsurance)
               0913 = Ganciclovir 4.5  mg, Implant (eligible for pass-
                        through payments)
               0914 = Reteplase, 37.6 mg (Two Single Use Vials)
                        (Not subject to national coinsurance)
               0915 = Alteplase recombinant, 10mg
                        (Not subject to national coinsurance)
               0916 = Imiglucerase per unit (eligible for pass-through
                        payments)
               0917 = Dipyridamole, 10mg / Adenosine 6MG
                        (Not subject to national coinsurance)
               0918 = Brachytherapy Seeds, Any type, Each (eligible
                        for pass-through payments)
               0925 = Factor VIII (Antihemophilic Factor, Human) per iu
                        (eligible for pass-through payments)
               0926 = Factor VIII (Antihemophilic Factor, Porcine) per  iu
                        (eligible for pass-through payments)
               0927 = Factor VIII (Antihemophilic Factor, Recombinant)
                        per iu (eligible for pass-through payments)
               0928 = Factor IX,  Complex (eligible for pass-through
                        payments)
               0929 = Other Hemophilia Clotting Factors per iu (eligible
                        for pass-through payments)
               0930 = Antithrombin III (Human) per iu (eligible for pass-
                        through payments)
               0931 = Factor IX (Antihemophilic Factor, Purified, Non-
                        Recombinant) (eligible for pass-through payments)
               0932 = Factor IX (Antihemophilic Factor, Recombinant)
                        (eligible for pass-through payments)
               0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent
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                                    Treated, Frozen (not subject to national coinsurance)
                            0950 = Blood (Whole) For Transfusion (not subject to
                                   national coinsurance)
1      REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
       ---------------              ----------------------------------------------------

                            0952 = Cryoprecipitate (not subject to national coinsurance)
                            0953 = Fibrinogen Unit (not subject to national coinsurance)
                            0954 = Leukocyte Poor Blood (not subject to national
                                   coinsurance)
                            0955 = Plasma, Fresh Frozen (not subject to national
                                   coinsurance)
                            0956 = Plasma Protein Fraction (not subject to national
                                   coinsurance)
                            0957 = Platelet Concentrate (not subject to national
                                   coinsurance)
                            0958 = Platelet Rich Plasma (not subject to national
                                   coinsurance)
                            0959 = Red Blood Cells (not subject to national coinsurance)
                            0960 = Washed Red Blood Cells (not subject to national
                                   coinsurance)
                            0961 = Infusion, Albumin (Human) 5%, 500 ml
                                   (not subject to national coinsurance)
                            0962 = Infusion, Albumin (Human) 25%, 50 ml
                                   (not subject to national coinsurance)
                            0970 = New Technology - Level I     ($0 - $50)
                                   (not subject to national coinsurance)
                            0971 = New Technology - Level II    ($50 - $100)
                                   (not subject to national coinsurance)
                            0972 = New Technology - Level III   ($100 - $200)
                                   (not subject to national coinsurance)
                            0973 = New Technology - Level IV    ($200 - $300)
                                   (not subject to national coinsurance)
                            0974 = New Technology - Level V     ($300 - $500)
                                   (not subject to national coinsurance)
                            0975 = New Technology - Level VI    ($500 - $750)
                                   (not subject to national coinsurance)
                            0976 = New Technology - Level VII   ($750 - $1000)
                                   (not subject to national coinsurance)
                            0977 = New Technology - Level VIII  ($1000 - $1250)
                                   (not subject to national coinsurance)
                            0978 = New Technology - Level IX    ($1250 - $1500)
                                   (not subject to national coinsurance)
                            0979 = New Technology - Level X     ($1500 - $1750)
                                   (not subject to national coinsurance)
                            0980 = New Technology - Level XI    ($1750 - $2000)
                                   (not subject to national coinsurance)
                            0981 = New Technology - Level XII   ($2000 - $2500)
                                   (not subject to national coinsurance)
                            0982 = New Technology - Level XIII  ($2500 - $3500)
                                   (not subject to national coinsurance)
                            0983 = New Technology - Level XIV   ($3500 - $5000)
                                   (not subject to national coinsurance)
                            0984 = New Technology - Level XV    ($5000 - $6000)
                                   (not subject to national coinsurance)
                            7000 = Amifostine, 500 mg (eligible for pass-through
                                   payments)
                            7001 = Amphotericin B lipid complex, 50 mg, Inj
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                                 (eligible for pass-through payments)
                     7002 = Clonidine, HCl, 1 MG (eligible for pass-
                            through payments)
                     7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-
                            through payments)
                     7004 = Immune globulin intravenous human 5g, inj
1      REV_CNTR_APC_TB       Revenue Center Ambulatory Payment Classification (APC)
       ---------------       ----------------------------------------------------

                                 (eligible for pass-through payments)
                     7005 = Gonadorelin hcI, 100 mcg (eligible for pass-
                            through payments)
                     7007 = Milrinone lacetate, per 5 ml, inj (not subject
                            to national coinsurance)
                     7010 = Morphine sulfate concentrate (preservative free)
                            per 10 mg (eligible for pass-through payments)
                     7011 = Oprelevekin, inj, 5 mg (eligible for pass-through
                            payments)
                     7012 = Pentamidine isethionate, 300 mg (eligible for
                            pass-through payments)
                     7014 = Fentanyl citrate, inj, up to 2 ml (eligible for
                            pass-through payments)
                     7015 = Busulfan, oral 2 mg (eligible for pass-through
                            payments)
                     7019 = Aprotinin, 10,000 kiu (eligible for pass-through
                            payments)
                     7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-
                            through payments)
                     7022 = Elliotts B Solution, per ml (eligible for pass-
                            through payments)
                     7023 = Treatment for bladder calculi, I.e. Renacidin
                            per 500 ml (eligible for pass-through payments)
                     7024 = Corticorelin ovine triflutate, 0.1 mg
                            (eligible for pass-through payments)
                     7025 = Digoxin immune FAB (Ovine), 10 mg
                            (eligible for pass-through payments)
                     7026 = Ethanolamine oleate, 1000 ml
                            (eligible for pass-through payments)
                     7027 = Fomepizole, 1.5 G
                            (eligible for pass-through payments)
                     7028 = Fosphenytoin, 50 mg
                            (eligible for pass-through payments)
                     7029 = Glatiramer acetate, 25 mg
                            (eligible for pass-through payments)
                     7030 = Hemin, 1 mg
                            (eligible for pass-through payments)
                     7031 = Octreotide Acetate, 500 mcg
                            (eligible for pass-through payments)
                     7032 = Sermorelin acetate, 0.5 mg
                            (eligible for pass-through payments)
                     7033 = Somatrem, 5 mg
                            (eligible for pass-through payments)
                     7034 = Somatropin, 1 mg
                            (eligible for pass-through payments)
                     7035 = Teniposide, 50 mg
                            (eligible for pass-through payments)
                     7036 = Urokinase, inj, IV, 250,000 I.U.
                            (not subject to national coinsurance)
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                      7037 = Urofollitropin, 75 I.U.
                             (eligible for pass-through payments)
                      7038 = Muromonab-CD3, 5 mg
                             (eligible for pass-through payments)
                      7039 = Pegademase bovine inj 25 I.U.
                             (eligible for pass-through payments)
                      7040 = Pentastarch 10% inj, 100 ml
                             (eligible for pass-through payments)
                      7041 = Tirofiban HCL, 0.5 mg
1       REV_CNTR_APC_TB                 Revenue Center Ambulatory Payment Classification (APC)
        ---------------                 ------------------------------------------------------

                             (not subject to national coinsurance)
                      7042 = Capecitabine, oral 150 mg
                             (eligible for pass-through payments)
                      7043 = Infliximab, 10 MG (eligible for pass-through
                             payments)
                      7045 = Trimetrexate Glucoronate (eligible for pass-
                             through payments)
                      7046 = Doxorubicin Hcl Liposome (eligible for pass-
                             through payments)


1 REV_CNTR_DDCTBL_COINSRNC_TB                    Revenue Center Deductible Coinsurance Code
  --------------------------                    ------------------------------------------


                      0 = Charges are subject to deductible
                          and coinsurance
                      1 = Charges are not subject to deductible
                      2 = Charges are not subject to coinsurance
                      3 = Charges are not subject to deductible
                          or coinsurance
                      4 = No charge or units associated with this
                          revenue center code.  (For multiple
                          HCPCS per single revenue center code)

                      For revenue center code 0001, the following
                      MSP override values may be present:

                      M = Override code; EGHP services involved
                          (eff 12/90 for non-institutional claims;
                          10/93 for institutional claims)
                      N = Override code; non-EGHP services involved
                          (eff 12/90 for non-institutional claims;
                          10/93 for institutional claims)
                      X = Override code: MSP cost avoided
                          (eff 12/90 for non-institutional claims;
                          10/93 for institutional claims)

1     REV_CNTR_PMT_MTHD_IND_TB              Revenue Center Payment Method Indicator Table
      ------------------------              ---------------------------------------------


                      **********Service Indicator**************
                      ********** 1st position *****************
                      A = Services not paid under OPPS
                      C = Inpatient procedure
                      E = Noncovered items or services
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                      F = Corneal issue acquistion
                      G = Current drug or biological pass-through
                      H = Device pass-through
                      J = New drug or new biological pass-through
                      N = Packaged incidental service
                      P = Partial hospitalization services
                      S = Significant procedure not subject to
                          multiple procedure discounting
                      T = Significant procedure subject to multiple
                          procedure discounting
                      V = Medical visit to clinic or emergency
                          department
                      X = Ancillary service

                      **********Payment Indicator**************
                      ********** 2nd position *****************
                      1 = Paid standard hospital OPPS amount
                          (service indicators S,T,V,X)
                      2 = Services not paid under OPPS (service
                          indicator A, or no HCPCS code and not
                          certain revenue center codes)
                      3 = Not paid (service indicators C & E)
                      4 = Acquisition cost paid (service indica-
                          tor F)
                      5 = Additional payment for current drug or
                          biological (service indicator G)
                      6 = Additional payment for device (service
                          indicator H)
                      7 = Additional payment for new drug or new
                          biological (service indicator J)
                      8 = Paid partial hospitalization per diem
                          (service indicator P)
                      9 = No additional payment, payment included
                          in line items with APCs (service
                          indicator N, or no HCPCS code and certain
                          revenue center codes, or HCPCS codes Q0082
                          (activity therapy), G0129 (occupational
                          therapy) or G0172 (partial hospitalization
                          training)

  1    REV_CNTR_PRICNG_IND_TB                   Revenue Center Pricing Indicator Table
       ----------------------                   --------------------------------------



                      A = A valid HCPCS code not subject to a fee schedule payment.
                          Reimbursement is calculated on provider submitted
                          charges.
                      B = A valid HCPCS code subject to the fee schedule payment.
                          Reimbursement is the lesser of provider submitted
                          charges or the fee schedule amount.
                      D = a valid radiology HCPCS code subject to the Radiology
                          Pricer and the rate is reflected as zeroes on the HCPCS
                          file and cost report.  The Radiology Pricer treats this
                          HCPCS as a non-covered service.  Reimbursement is cal-
                          culated on provider submitted charges.
                      E = A valid ASC HCPCS code subject to the ASC Pricer. The
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                      rate is reflected as zeroes on the HCPCS file.  The
                      ASC Pricer determines the ASC payment rate and is re-
                      ported on the cost report.
                  F = A valid ESRD HCPCS code subject to the parameter rate.
                      Reimbursement is the lesser of provider submitted
                      charges or the fee schedule amount for non-dialysis
                      HCPCS.  Reimbursement is calculated on the provider
                      file rates for dialysis HCPCS.
                  G = A valid HCPCS, code is subject to a fee schedule, but
                      the rate is no longer present on the HCPCS file.
                      Reimbursement is calculated on provider submitted
                      charges.
                  H = A valid DME HCPCS, code is subject to a fee schedule.
                      The rates are reflected under the DME segment.  Reim-
                      bursement is calculated either on a fee schedule, pro-
                      vider submitted charges or the lesser of provider
                      submitted, or the fee schedule depending o the cate-
                      gory.
                  I = A valid DME category 5 HCPCS, HCPCS is not found on
                      the DME history record, but a match was found on HIC,
                      category and generic code.  Claim must be reviewed by
                      Medical Review before payment can be calculated.
                  J = A valid DME HCPCS, no DME history is present, and a
                      prescription is required before delivery.  Claim must
                      be reviewed by Medical Review.
                  K = A valid DME HCPCS, prescribed has been reviewed, and
                      fee schedule payment is approved as prescription was
                      present before delivery.
                  L = A valid TENS HCPCS, rental period is six months or
                      greater and must be reviewed by Medical Review.
                  M = A valid TENS HCPCS, Medical Review has approved the
                      rental charge in excess of five months.
                  R = A valid radiology HCPCS code and is subject to the
                      Radiology Pricer.  The rate is reported on the cost
                      report.  Reimbursement is calculated on provider
                      submitted charges.
                  S = Valid influenza/PPV HCPCS.  A fee amount is not
                      applicable.  The amount payable is present in the
                      covered charge field.  This amount is not subject
                      to the coinsurance and deductible.  This charge is
                      subject to the provider's reimbursement rate.
                  T = Valid HCPCS.  A fee amount is present.  The amount
                      payable should be the lower of the billed charge or
1    REV_CNTR_PRICNG_IND_TB              Revenue Center Pricing Indicator Table
     ----------------------              --------------------------------------

                      fee amount.  The system should compute the fee amount
                      by multiplying the covered units times the rate.
                      The fee amount is not subject to coinsurance and
                      deductible or provider's reimbursement rate.


1      REV_CNTR_TB                              Revenue Center Table
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                  0001 = Total charge
                  0022 = SNF claim paid under PPS submitted as TOB 21X,
                         effective for cost reporting periods begin-
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                       ning on or after 7/1/98 (dates of service after
                       6/30/98).  NOTE:  This code may appear multiple
                       times on a claim to identify different HIPPS
                       Rate Code/assessment periods.
               0023 = Home Health services paid under PPS submitted as
                       TOB 32X and 33X, effective 10/00.  This code may
                       appear multiple times on a claim to identify
                       different HIPPS/Home Health Resource Groups (HRG).
               0100 = All inclusive rate-room and board plus ancillary
               0101 = All inclusive rate-room and board
               0110 = Private medical or general-general classification
               0111 = Private medical or general-medical/surgical/GYN
               0112 = Private medical or general-OB
               0113 = Private medical or general-pediatric
               0114 = Private medical or general-psychiatric
               0115 = Private medical or general-hospice
               0116 = Private medical or general-detoxification
               0117 = Private medical or general-oncology
               0118 = Private medical or general-rehabilitation
               0119 = Private medical or general-other
               0120 = Semi-private 2 bed (medical or general)
                       general classification
               0121 = Semi-private 2 bed (medical or general)
                       medical/surgical/GYN
               0122 = Semi-private 2 bed (medical or general)-OB
               0123 = Semi-private 2 bed (medical or general)-pediatric
               0124 = Semi-private 2 bed (medical or general)-psychiatric
               0125 = Semi-private 2 bed (medical or general)-hospice
               0126 = Semi-private 2 bed (medical or general)
                       detoxification
               0127 = Semi-private 2 bed (medical or general)-oncology
               0128 = Semi-private 2 bed (medical or general)
                       rehabilitation
               0129 = Semi-private 2 bed (medical or general)-other
               0130 = Semi-private 3 and 4 beds-general classification
               0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
               0132 = Semi-private 3 and 4 beds-OB
               0133 = Semi-private 3 and 4 beds-pediatric
               0134 = Semi-private 3 and 4 beds-psychiatric
               0135 = Semi-private 3 and 4 beds-hospice
               0136 = Semi-private 3 and 4 beds-detoxification
               0137 = Semi-private 3 and 4 beds-oncology
               0138 = Semi_private 3 and 4 beds-rehabilitation
               0139 = Semi-private 3 and 4 beds-other
               0140 = Private (deluxe)-general classification
               0141 = Private (deluxe)-medical/surgical/GYN
               0142 = Private (deluxe)-OB
               0143 = Private (deluxe)-pediatric
               0144 = Private (deluxe)-psychiatric
               0145 = Private (deluxe)-hospice
               0146 = Private (deluxe)-detoxification
               0147 = Private (deluxe)-oncology
               0148 = Private (deluxe)-rehabilitation
               0149 = Private (deluxe)-other
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1   REV_CNTR_TB   Revenue Center Table
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               0150 = Room&Board ward (medical or general)
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          general classification
0151 = Room&Board ward (medical or general)
          medical/surgical/GYN
0152 = Room&Board ward (medical or general)-OB
0153 = Room&Board ward (medical or general)-pediatric
0154 = Room&Board ward (medical or general)-psychiatric
0155 = Room&Board ward (medical or general)-hospice
0156 = Room&Board ward (medical or general)-detoxification
0157 = Room&Board ward (medical or general)-oncology
0158 = Room&Board ward (medical or general)-rehabilitation
0159 = Room&Board ward (medical or general)-other
0160 = Other Room&Board-general classification
0164 = Other Room&Board-sterile environment
0167 = Other Room&Board-self care
0169 = Other Room&Board-other
0170 = Nursery-general classification
0171 = Nursery-newborn
          level I (routine)
0172 = Nursery-premature
          newborn-level II (continuing care)
0173 = Nursery-newborn-level III (intermediate care)
          (eff 10/96)
0174 = Nursery-newborn-level IV (intensive care)
          (eff 10/96)
0175 = Nursery-neonatal ICU (obsolete eff 10/96)
0179 = Nursery-other
0180 = Leave of absence-general classification
0182 = Leave of absence-patient convenience charges
          billable
0183 = Leave of absence-therapeutic leave
0184 = Leave of absence-ICF mentally retarded-any reason
0185 = Leave of absence-nursing home (hospitalization)
0189 = Leave of absence-other leave of absence
0190 = Subacute care - general classification
          (eff. 10/97)
0191 = Subacute care - level I (eff. 10/97)
0192 = Subacute care - level II (eff. 10/97)
0193 = Subacute care - level III (eff. 10/97)
0194 = Subacute care - level IV (eff. 10/97)
0199 = Subacute care - other (eff 10/97)
0200 = Intensive care-general classification
0201 = Intensive care-surgical
0202 = Intensive care-medical
0203 = Intensive care-pediatric
0204 = Intensive care-psychiatric
0206 = Intensive care-post ICU; redefined as
          intermediate ICU (eff 10/96)
0207 = Intensive care-burn care
0208 = Intensive care-trauma
0209 = Intensive care-other intensive care
0210 = Coronary care-general classification
0211 = Coronary care-myocardial infraction
0212 = Coronary care-pulmonary care
0213 = Coronary care-heart transplant
0214 = Coronary care-post CCU; redefined as
          intermediate CCU (eff 10/96)
0219 = Coronary care-other coronary care
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           0220 = Special charges-general classification
           0221 = Special charges-admission charge
           0222 = Special charges-technical support charge
           0223 = Special charges-UR service charge
           0224 = Special charges-late discharge, medically
                  necessary
           0229 = Special charges-other special charges
           0230 = Incremental nursing charge rate-general
                  classification
           0231 = Incremental nursing charge rate-nursery
           0232 = Incremental nursing charge rate-OB
           0233 = Incremental nursing charge rate-ICU (include
                  transitional care)
           0234 = Incremental nursing charge rate-CCU (include
                  transitional care)
           0235 = Incremental nursing charge rate-hospice
           0239 = Incremental nursing charge rate-other
           0240 = All inclusive ancillary-general classification
           0241 = All inclusive ancillary-basic
           0242 = All inclusive ancillary-comprehensive
           0243 = All inclusive ancillary-specialty
           0249 = All inclusive ancillary-other inclusive ancillary
           0250 = Pharmacy-general classification
           0251 = Pharmacy-generic drugs
           0252 = Pharmacy-nongeneric drugs
           0253 = Pharmacy-take home drugs
           0254 = Pharmacy-drugs incident to other diagnostic service-
                  subject to payment limit
           0255 = Pharmacy-drugs incident to radiology-
                  subject to payment limit
           0256 = Pharmacy-experimental drugs
           0257 = Pharmacy-non-prescription
           0258 = Pharmacy-IV solutions
           0259 = Pharmacy-other pharmacy
           0260 = IV therapy-general classification
           0261 = IV therapy-infusion pump
           0262 = IV therapy-pharmacy services (eff 10/94)
           0263 = IV therapy-drug supply/delivery (eff 10/94)
           0264 = IV therapy-supplies (eff 10/94)
           0269 = IV therapy-other IV therapy
           0270 = Medical/surgical supplies-general classification
                  (also see 062X)
           0271 = Medical/surgical supplies-nonsterile supply
           0272 = Medical/surgical supplies-sterile supply
           0273 = Medical/surgical supplies-take home supplies
           0274 = Medical/surgical supplies-prosthetic/orthotic
                  devices
           0275 = Medical/surgical supplies-pace maker
           0276 = Medical/surgical supplies-intraocular lens
           0277 = Medical/surgical supplies-oxygen-take home
           0278 = Medical/surgical supplies-other implants
           0279 = Medical/surgical supplies-other devices
           0280 = Oncology-general classification
           0289 = Oncology-other oncology
           0290 = DME (other than renal)-general classification
           0291 = DME (other than renal)-rental
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                                   0292 = DME (other than renal)-purchase of new DME
                                   0293 = DME (other than renal)-purchase of used DME
1          REV_CNTR_TB                           Revenue Center Table
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                                   0294 = DME (other than renal)-related to and listed as DME
                                   0299 = DME (other than renal)-other
                                   0300 = Laboratory-general classification
                                   0301 = Laboratory-chemistry
                                   0302 = Laboratory-immunology
                                   0303 = Laboratory-renal patient (home)
                                   0304 = Laboratory-non-routine dialysis
                                   0305 = Laboratory-hematology
                                   0306 = Laboratory-bacteriology & microbiology
                                   0307 = Laboratory-urology
                                   0309 = Laboratory-other laboratory
                                   0310 = Laboratory pathological-general classification
                                   0311 = Laboratory pathological-cytology
                                   0312 = Laboratory pathological-histology
                                   0314 = Laboratory pathological-biopsy
                                   0319 = Laboratory pathological-other
                                   0320 = Radiology diagnostic-general classification
                                   0321 = Radiology diagnostic-angiocardiography
                                   0322 = Radiology diagnostic-arthrography
                                   0323 = Radiology diagnostic-arteriography
                                   0324 = Radiology diagnostic-chest X-ray
                                   0329 = Radiology diagnostic-other
                                   0330 = Radiology therapeutic-general classification
                                   0331 = Radiology therapeutic-chemotherapy injected
                                   0332 = Radiology therapeutic-chemotherapy oral
                                   0333 = Radiology therapeutic-radiation therapy
                                   0335 = Radiology therapeutic-chemotherapy IV
                                   0339 = Radiology therapeutic-other
                                   0340 = Nuclear medicine-general classification
                                   0341 = Nuclear medicine-diagnostic
                                   0342 = Nuclear medicine-therapeutic
                                   0349 = Nuclear medicine-other
                                   0350 = Computed tomographic (CT) scan-general
                                          classification
                                   0351 = CT scan-head scan
                                   0352 = CT scan-body scan
                                   0359 = CT scan-other CT scans
                                   0360 = Operating room services-general classification
                                   0361 = Operating room services-minor surgery
                                   0362 = Operating room services-organ transplant,
                                          other than kidney
                                   0367 = Operating room services-kidney transplant
                                   0369 = Operating room services-other operating room
                                          services
                                   0370 = Anesthesia-general classification
                                   0371 = Anesthesia-incident to RAD and
                                          subject to the payment limit
                                   0372 = Anesthesia-incident to other diagnostic service
                                          and subject to the payment limit
                                   0374 = Anesthesia-acupuncture
                                   0379 = Anesthesia-other anesthesia
                                   0380 = Blood-general classification
                                   0381 = Blood-packed red cells
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                              0382 = Blood-whole blood
                              0383 = Blood-plasma
                              0384 = Blood-platelets
                              0385 = Blood-leukocytes
                              0386 = Blood-other components
1         REV_CNTR_TB                           Revenue Center Table
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                              0387 = Blood-other derivatives (cryopricipatates)
                              0389 = Blood-other blood
                              0390 = Blood storage and processing-general
                                     classification
                              0391 = Blood storage and processing-blood
                                     administration
                              0399 = Blood storage and processing-other
                              0400 = Other imaging services-general classification
                              0401 = Other imaging services-diagnostic mammography
                              0402 = Other imaging services-ultrasound
                              0403 = Other imaging services-screening mammography
                                     (eff 1/1/91)
                              0404 = Other imaging services-positron emission
                                     tomography (eff 10/94)
                              0409 = Other imaging services-other
                              0410 = Respiratory services-general classification
                              0412 = Respiratory services-inhalation services
                              0413 = Respiratory services-hyperbaric oxygen therapy
                              0419 = Respiratory services-other
                              0420 = Physical therapy-general classification
                              0421 = Physical therapy-visit charge
                              0422 = Physical therapy-hourly charge
                              0423 = Physical therapy-group rate
                              0424 = Physical therapy-evaluation or re-evaluation
                              0429 = Physical therapy-other
                              0430 = Occupational therapy-general classification
                              0431 = Occupational therapy-visit charge
                              0432 = Occupational therapy-hourly charge
                              0433 = Occupational therapy-group rate
                              0434 = Occupational therapy-evaluation or re-evaluation
                              0439 = Occupational therapy-other (may include
                                     restorative therapy)
                              0440 = Speech language pathology-general classification
                              0441 = Speech language pathology-visit charge
                              0442 = Speech language pathology-hourly charge
                              0443 = Speech language pathology-group rate
                              0444 = Speech language pathology-evaluation or
                                     re-evaluation
                              0449 = Speech language pathology-other
                              0450 = Emergency room-general classification
                              0451 = Emergency room-emtala emergency medical screening
                                     services (eff 10/96)
                              0452 = Emergency room-ER beyond emtala screening
                                     (eff 10/96)
                              0456 = Emergency room-urgent care (eff 10/96)
                              0459 = Emergency room-other
                              0460 = Pulmonary function-general classification
                              0469 = Pulmonary function-other
                              0470 = Audiology-general classification
                              0471 = Audiology-diagnostic
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                              0472 = Audiology-treatment
                              0479 = Audiology-other
                              0480 = Cardiology-general classification
                              0481 = Cardiology-cardiac cath lab
                              0482 = Cardiology-stress test
                              0483 = Cardiology-Echocardiology
                              0489 = Cardiology-other
                              0490 = Ambulatory surgical care-general classification
1        REV_CNTR_TB                          Revenue Center Table
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                              0499 = Ambulatory surgical care-other
                              0500 = Outpatient services-general classification
                                     (deleted 9/93)
                              0509 = Outpatient services-other (deleted 9/93)
                              0510 = Clinic-general classification
                              0511 = Clinic-chronic pain center
                              0512 = Clinic-dental center
                              0513 = Clinic-psychiatric
                              0514 = Clinic-OB-GYN
                              0515 = Clinic-pediatric
                              0516 = Clinic-urgent care clinic (eff 10/96)
                              0517 = Clinic-family practice clinic (eff 10/96)
                              0519 = Clinic-other
                              0520 = Free-standing clinic-general classification
                              0521 = Free-standing clinic-rural health clinic
                              0522 = Free-standing clinic-rural health home
                              0523 = Free-standing clinic-family practice
                              0526 = Free-standing clinic-urgent care (eff 10/96)
                              0529 = Free-standing clinic-other
                              0530 = Osteopathic services-general classification
                              0531 = Osteopathic services-osteopathic therapy
                              0539 = Osteopathic services-other
                              0540 = Ambulance-general classification
                              0541 = Ambulance-supplies
                              0542 = Ambulance-medical transport
                              0543 = Ambulance-heart mobile
                              0544 = Ambulance-oxygen
                              0545 = Ambulance-air ambulance
                              0546 = Ambulance-neo-natal ambulance
                              0547 = Ambulance-pharmacy
                              0548 = Ambulance-telephone transmission EKG
                              0549 = Ambulance-other
                              0550 = Skilled nursing-general classification
                              0551 = Skilled nursing-visit charge
                              0552 = Skilled nursing-hourly charge
                              0559 = Skilled nursing-other
                              0560 = Medical social services-general classification
                              0561 = Medical social services-visit charge
                              0562 = Medical social services-hourly charges
                              0569 = Medical social services-other
                              0570 = Home health aid (home health)-general
                                     classification
                              0571 = Home health aid (home health)-visit charge
                              0572 = Home health aid (home health)-hourly charge
                              0579 = Home health aid (home health)-other
                              0580 = Other visits (home health)-general
                                     classification (under HHPPS, not allowed
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                              as covered charges)
                   0581 = Other visits (home health)-visit charge
                              (under HHPPS, not allowed as covered charges)
                   0582 = Other visits (home health)-hourly charge
                              (under HHPPS, not allowed as covered charges)
                   0589 = Other visits (home health)-other
                              (under HHPPS, not allowed as covered charges)
                   0590 = Units of service (home health)-general
                              classification (under HHPPS, not allowed
                              as covered charges)
                   0599 = Units of service (home health)-other
1        REV_CNTR_TB                           Revenue Center Table
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                              (under HHPPS, not allowed as covered charges)
                   0600 = Oxygen-general classification
                   0601 = Oxygen-stat or port equip/supply or count
                   0602 = Oxygen-stat/equip/under 1 LPM
                   0603 = Oxygen-stat/equip/over 4 LPM
                   0604 = Oxygen-stat/equip/portable add-on
                   0610 = Magnetic resonance technology (MRT)-general
                              classification
                   0611 = MRT/MRI-brain (including brainstem)
                   0612 = MRT/MRI-spinal cord (including spine)
                   0614 = MRT/MRI-other
                   0615 = MRT/MRA-Head and Neck
                   0616 = MRT/MRA-Lower Extremities
                   0618 = MRT/MRA-other
                   0619 = MRT/Other MRI
                   0621 = Medical/surgical supplies-incident to radiology-
                              subject to the payment limit - extension of 027X
                   0622 = Medical/surgical supplies-incident to other
                              diagnostic service-subject to the payment limit -
                              extension of 027X
                   0623 = Medical/surgical supplies-surgical dressings
                              (eff 1/95) - extension of 027X
                   0624 = Medical/surgical supplies-medical investigational
                              devices and procedures with FDA approved IDE's
                              (eff 10/96) - extension of 027X
                   0630 = Drugs requiring specific identification-general
                              classification
                   0631 = Drugs requiring specific identification-single drug
                              source (eff 9/93)
                   0632 = Drugs requiring specific identification-multiple drug
                              source (eff 9/93)
                   0633 = Drugs requiring specific identification-restrictive
                              prescription (eff 9/93)
                   0634 = Drugs requiring specific identification-EPO under
                              10,000 units
                   0635 = Drugs requiring specific identification-EPO 10,000
                              units or more
                   0636 = Drugs requiring specific identification-detailed
                              coding (eff 3/92)
                   0637 = Self-administered drugs administered in an
                              emergency situation - not requiring detailed
                              coding
                   0640 = Home IV therapy-general classification
                              (eff 10/94)
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                          0641 = Home IV therapy-nonroutine nursing
                                 (eff 10/94)
                          0642 = Home IV therapy-IV site care, central line
                                 (eff 10/94)
                          0643 = Home IV therapy-IV start/change peripheral line
                                 (eff 10/94)
                          0644 = Home IV therapy-nonroutine nursing, peripheral line
                                 (eff 10/94)
                          0645 = Home IV therapy-train patient/caregiver, central
                                 line (eff 10/94)
                          0646 = Home IV therapy-train disabled patient, central
                                 line (eff 10/94)
                          0647 = Home IV therapy-train patient/caregiver, peripheral
                                 line (eff 10/94)
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1   REV_CNTR_TB   Revenue Center Table
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                          0648 = Home IV therapy-train disabled patient, peripheral
                                 line (eff 10/94)
                          0649 = Home IV therapy-other IV therapy services
                                 (eff 10/94)
                          0650 = Hospice services-general classification
                          0651 = Hospice services-routine home care
                          0652 = Hospice services-continuous home care-1/2
                          0655 = Hospice services-inpatient care
                          0656 = Hospice services-general inpatient care
                                 (non-respite)
                          0657 = Hospice services-physician services
                          0659 = Hospice services-other
                          0660 = Respite care (HHA)-general classification
                                 (eff 9/93)
                          0661 = Respite care (HHA)-hourly charge/skilled nursing
                                 (eff 9/93)
                          0662 = Respite care (HHA)-hourly charge/home health aide/
                                 homemaker (eff 9/93)
                          0670 = OP special residence charges - general
                                 classification
                          0671 = OP special residence charges - hospital based
                          0672 = OP special residence charges - contracted
                          0679 = OP special residence charges - other special
                                 residence charges
                          0700 = Cast room-general classification
                          0709 = Cast room-other
                          0710 = Recovery room-general classification
                          0719 = Recovery room-other
                          0720 = Labor room/delivery-general classification
                          0721 = Labor room/delivery-labor
                          0722 = Labor room/delivery-delivery
                          0723 = Labor room/delivery-circumcision
                          0724 = Labor room/delivery-birthing center
                          0729 = Labor room/delivery-other
                          0730 = EKG/ECG-general classification
                          0731 = EKG/ECG-Holter moniter
                          0732 = EKG/ECG-telemetry (include fetal monitering until
                                 9/93)
                          0739 = EKG/ECG-other
                          0740 = EEG-general classification
                          0749 = EEG (electroencephalogram)-other
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                      0750 = Gastro-intestinal services-general classification
                      0759 = Gastro-intestinal services-other
                      0760 = Treatment or observation room-general
                             classification
                      0761 = Treatment or observation room-treatment room
                             (eff 9/93)
                      0762 = Treatment or observation room-observation room
                             (eff 9/93)
                      0769 = Treatment or observation room-other
                      0770 = Preventative care services-general classification
                             (eff 10/94)
                      0771 = Preventative care services-vaccine administration
                             (eff 10/94)
                      0779 = Preventative care services-other (eff 10/94)
                      0780 = Telemedicine - general classification
                             (eff 10/97)
                      0789 = Telemedicine - telemedicine (eff 10/97)
1        REV_CNTR_TB                         Revenue Center Table
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                      0790 = Lithotripsy-general classification
                      0799 = Lithotripsy-other
                      0800 = Inpatient renal dialysis-general classification
                      0801 = Inpatient renal dialysis-inpatient hemodialysis
                      0802 = Inpatient renal dialysis-inpatient peritoneal
                             (non-CAPD)
                      0803 = Inpatient renal dialysis-inpatient CAPD
                      0804 = Inpatient renal dialysis-inpatient CCPD
                      0809 = Inpatient renal dialysis-other inpatient dialysis
                      0810 = Organ acquisition-general classification
                      0811 = Organ acquisition-living donor (eff 10/94);
                             prior to 10/94, defined as living donor kidney
                      0812 = Organ acquisition-cadaver donor (eff 10/94);
                             prior to 10/94, defined as cadaver donor kidney
                      0813 = Organ acquisition-unknown donor (eff 10/94)
                             prior to 10/94, defined as unknown donor kidney
                      0814 = Organ acquisition - unsuccessful organ search-
                             donor bank charges (eff 10/94); prior to 10/94,
                             defined as other kidney acquisition
                      0815 = Organ acquisition-cadaver donor-heart
                             (obsolete, eff 10/94)
                      0816 = Organ acquisition-other heart acquisition
                             (obsolete, eff 10/94)
                      0817 = Organ acquisition-donor-liver
                             (obsolete, eff 10/94)
                      0819 = Organ acquisition-other donor (eff 10/94);
                             prior to 10/94, defined as other
                      0820 = Hemodialysis OP or home dialysis-general
                             classification
                      0821 = Hemodialysis OP or home dialysis-hemodialysis-
                             composite or other rate
                      0822 = Hemodialysis OP or home dialysis-home supplies
                      0823 = Hemodialysis OP or home dialysis-home equipment
                      0824 = Hemodialysis OP or home dialysis-maintenance/100%
                      0825 = Hemodialysis OP or home dialysis-support services
                      0829 = Hemodialysis OP or home dialysis-other
                      0830 = Peritoneal dialysis OP or home-general
                             classification
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          0831 = Peritoneal dialysis OP or home-peritoneal-
                 composite or other rate
          0832 = Peritoneal dialysis OP or home-home supplies
          0833 = Peritoneal dialysis OP or home-home equipment
          0834 = Peritoneal dialysis OP or home-maintenance/100%
          0835 = Peritoneal dialysis OP or home-support services
          0839 = Peritoneal dialysis OP or home-other
          0840 = CAPD outpatient-general classification
          0841 = CAPD outpatient-CAPD/composite or other rate
          0842 = CAPD outpatient-home supplies
          0843 = CAPD outpatient-home equipment
          0844 = CAPD outpatient-maintenance/100%
          0845 = CAPD outpatient-support services
          0849 = CAPD outpatient-other
          0850 = CCPD outpatient-general classification
          0851 = CCPD outpatient-CCPD/composite or other rate
          0852 = CCPD outpatient-home supplies
          0853 = CCPD outpatient-home equipment
          0854 = CCPD outpatient-maintenance/100%
          0855 = CCPD outpatient-support services
1      REV_CNTR_TB                            Revenue Center Table
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          0859 = CCPD outpatient-other
          0880 = Miscellaneous dialysis-general classification
          0881 = Miscellaneous dialysis-ultrafiltration
          0882 = Miscellaneous dialysis-home dialysis aide visit
                 (eff 9/93)
          0889 = Miscellaneous dialysis-other
          0890 = Other donor bank-general classification; changed to
                 reserved for national assignment (eff 4/94)
          0891 = Other donor bank-bone; changed to
                 reserved for national assignment (eff 4/94)
          0892 = Other donor bank-organ (other than kidney); changed
                 to reserved for national assignment (eff 4/94)
          0893 = Other donor bank-skin; changed to
                 reserved for national assignment (eff 4/94)
          0899 = Other donor bank-other; changed to
                 reserved for national assignment (eff 4/94)
          0900 = Psychiatric/psychological treatments-general
                 classification
          0901 = Psychiatric/psychological treatments-electroshock
                 treatment
          0902 = Psychiatric/psychological treatments-milieu
                 therapy
          0903 = Psychiatric/psychological treatments-play
                 therapy
          0904 = Psychiatric/psychological treatments-activity
                 therapy (eff 4/94)
          0909 = Psychiatric/psychological treatments-other
          0910 = Psychiatric/psychological services-general
                 classification
          0911 = Psychiatric/psychological services-rehabilitation
          0912 = Psychiatric/psychological services-day care-
                 redefined 10/97 to less Intensive
          0913 = Psychiatric/psychological services-night care
                 redefined 10/97 to Intensive
          0914 = Psychiatric/psychological services-individual
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                    therapy
         0915 = Psychiatric/psychological services-group therapy
         0916 = Psychiatric/psychological services-family therapy
         0917 = Psychiatric/psychological services-biofeedback
         0918 = Psychiatric/psychological services-testing
         0919 = Psychiatric/psychological services-other
         0920 = Other diagnostic services-general classification
         0921 = Other diagnostic services-peripheral vascular lab
         0922 = Other diagnostic services-electromyelogram
         0923 = Other diagnostic services-pap smear
         0924 = Other diagnostic services-allergy test
         0925 = Other diagnostic services-pregnancy test
         0929 = Other diagnostic services-other
         0940 = Other therapeutic services-general classification
         0941 = Other therapeutic services-recreational therapy
         0942 = Other therapeutic services-education/training
                    (include diabetes diet training)
         0943 = Other therapeutic services-cardiac rehabilitation
         0944 = Other therapeutic services-drug rehabilitation
         0945 = Other therapeutic services-alcohol
                    rehabilitation
         0946 = Other therapeutic services-routine complex
                    medical equipment
1        REV_CNTR_TB                         Revenue Center Table
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         0947 = Other therapeutic services-ancillary complex
                    medical equipment (eff 3/92)
         0949 = Other therapeutic services-other
         0951 = Professional Fees-athletic training
         0952 = Professional Fees-kinesiotherapy
         0960 = Professional fees-general classification
         0961 = Professional fees-psychiatric
         0962 = Professional fees-ophthalmology
         0963 = Professional fees-anesthesiologist (MD)
         0964 = Professional fees-anesthetist (CRNA)
         0969 = Professional fees-other
         0971 = Professional fees-laboratory
         0972 = Professional fees-radiology diagnostic
         0973 = Professional fees-radiology therapeutic
         0974 = Professional fees-nuclear medicine
         0975 = Professional fees-operating room
         0976 = Professional fees-respiratory therapy
         0977 = Professional fees-physical therapy
         0978 = Professional fees-occupational therapy
         0979 = Professional fees-speech pathology
         0981 = Professional fees-emergency room
         0982 = Professional fees-outpatient services
         0983 = Professional fees-clinic
         0984 = Professional fees-medical social services
         0985 = Professional fees-EKG
         0986 = Professional fees-EEG
         0987 = Professional fees-hospital visit
         0988 = Professional fees-consultation
         0989 = Professional fees-private duty nurse
         0990 = Patient convenience items-general classification
         0991 = Patient convenience items-cafeteria/guest tray
         0992 = Patient convenience items-private linen service
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                      0993 = Patient convenience items-telephone/telegraph
                      0994 = Patient convenience items-tv/radio
                      0995 = Patient convenience items-nonpatient room rentals
                      0996 = Patient convenience items-late discharge charge
                      0997 = Patient convenience items-admission kits
                      0998 = Patient convenience items-beauty shop/barber
                      0999 = Patient convenience items-other

                      NOTE: Following Revenue Codes reported
                      for NHCMQ (RUGS) demo claims effective
                      2/96.

                      9000 = RUGS-no MDS assessment available
                      9001 = Reduced physical functions-
                             RUGS PA1/ADL index of 4-5
                      9002 = Reduced physical functions-
                             RUGS PA2/ADL index of 4-5
                      9003 = Reduced physical functions-
                             RUGS PB1/ADL index of 6-8
                      9004 = Reduced physical functions-
                             RUGS PB2/ADL index of 6-8
                      9005 = Reduced physical functions-
                             RUGS PC1/ADL index of 9-10
                      9006 = Reduced physical functions-
                             RUGS PC2/ADL index of 9-10
                      9007 = Reduced physical functions-
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                             RUGS PD1/ADL index of 11-15
                      9008 = Reduced physical functions-
                             RUGS PD2/ADL index of 11-15
                      9009 = Reduced physical functions-
                             RUGS PE1/ADL index of 16-18
                      9010 = Reduced physical functions-
                             RUGS PE2/ADL index of 16-18
                      9011 = Behavior only problems-
                             RUGS BA1/ADL index of 4-5
                      9012 = Behavior only problems-
                             RUGS BA2/ADL index of 4-5
                      9013 = Behavior only problems-
                             RUGS BB1/ADL index of 6-10
                      9014 = Behavior only problems-
                             RUGS BB2/ADL index of 6-10
                      9015 = Impaired cognition-
                             RUGS IA1/ADL index of 4-5
                      9016 = Impaired cognition-
                             RUGS IA2/ADL index of 4-5
                      9017 = Impaired cognition-
                             RUGS IB1/ADL index of 6-10
                      9018 = Impaired cognition-
                             RUGS IB2/ADL index of 6-10
                      9019 = Clinically complex-
                             RUGS CA1/ADL index of 4-5
                      9020 = Clinically complex-
                             RUGS CA2/ADL index of 4-5d
                      9021 = Clinically complex-
                             RUGS CB1/ADL index of 6-10
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                             9022 = Clinically complex-
                                    RUGS CB2/ADL index of 6-10d
                             9023 = Clinically complex-
                                    RUGS CC1/ADL index of 11-16
                             9024 = Clinically complex-
                                    RUGS CC2/ADL index of 11-16d
                             9025 = Clinically complex-
                                    RUGS CD1/ADL index of 17-18
                             9026 = Clinically complex-
                                    RUGS CD2/ADL index of 17-18d
                             9027 = Special care-
                                    RUGS SSA/ADL index of 7-13
                             9028 = Special care-
                                    RUGS SSB/ADL index of 14-16
                             9029 = Special care-
                                    RUGS SSC/ADL index of 17-18
                             9030 = Extensive services-
                                    RUGS SE1/1 procedure
                             9031 = Extensive services-
                                    RUGS SE2/2 procedures
                             9032 = Extensive services-
                                    RUGS SE3/3 procedures
                             9033 = Low rehabilitation-
                                    RUGS RLA/ADL index of 4-11
                             9034 = Low rehabilitation-
                                    RUGS RLB/ADL index of 12-18
                             9035 = Medium rehabilitation-
                                    RUGS RMA/ADL index of 4-7
                             9036 = Medium rehabilitation-
1        REV_CNTR_TB                              Revenue Center Table
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                                    RUGS RMB/ADL index of 8-15
                             9037 = Medium rehabilitation-
                                    RUGS RMC/ADL index of 16-18
                             9038 = High rehabilitation-
                                    RUGS RHA/ADL index of 4-7
                             9039 = High rehabilitation-
                                    RUGS RHB/ADL index of 8-11
                             9040 = High rehabilitation-
                                    RUGS RHC/ADL index of 12-14
                             9041 = High rehabilitation-
                                    RUGS RHD/ADL index of 15-18
                             9042 = Very high rehabilitation-
                                    RUGS RVA/ADL index of 4-7
                             9043 = Very high rehabilitation-
                                    RUGS RVB/ADL index of 8-13
                             9044 = Very high rehabilitation-
                                    RUGS RVC/ADL index of 14-18

                             ***Changes effective for providers entering***
                             **RUGS Demo Phase III as of 1/1/97 or later**

                             9019 = Clinically complex-
                                    RUGS CA1/ADL index of 11
                             9020 = Clinically complex-
                                    RUGS CA2/ADL index of 11D
                             9021 = Clinically complex-
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                          RUGS CB1/ADL index of 12-16
             9022 = Clinically complex-
                          RUGS CB2/ADL index of 12-16D
             9023 = Clinically complex-
                          RUGS CC1/ADL index of 17-18
             9024 = Clinically complex-
                          RUGS CC2/ADL index of 17-18D
             9025 = Special care-
                          RUGS SSA/ADL index of 14
             9026 = Special care-
                          RUGS SSB/ADL index of 15-16
             9027 = Special care-
                          RUGS SSC/ADL index of 17-18
             9028 = Extensive services-
                          RUGS SE1/ADL index 7-18/1 procedure
             9029 = Extensive services-
                          RUGS SE2/ADL index 7-18/2 procedures
             9030 = Extensive services-
                          RUGS SE3/ADL index 7-18/3 procedures
             9031 = Low rehabilitation-
                          RUGS RLA/ADL index of 4-13
             9032 = Low rehabilitation-
                          RUGS RLB/ADL index of 14-18
             9033 = Medium rehabilitation-
                          RUGS RMA/ADL index of 4-7
             9034 = Medium rehabilitation-
                          RUGS RMB/ADL index of 8-14
             9035 = Medium rehabilitation-
                          RUGS RMC/ADL index of 15-18
             9036 = High rehabilitation-
                          RUGS RHA/ADL index of 4-7
             9037 = High rehabilitation-
1      REV_CNTR_TB                               Revenue Center Table
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                          RUGS RHB/ADL index of 8-12
             9038 = High rehabilitation-
                          RUGS RHC/ADL index of 13-18
             9039 = Very High rehabilitation-
                          RUGS RVA/ADL index of 4-8
             9040 = Very high rehabilitation-
                          RUGS RVB/ADL index of 9-15
             9041 = Very high rehabilitation-
                          RUGS RVC/ADL index of 16
             9042 = Very high rehabilitation-
                          RUGS RUA/ADL index of 4-8
             9043 = Very high rehabilitation-
                          RUGS RUB/ADL index of 9-15
             9044 = Ultra high rehabilitation-
                          RUGS RUC/ADL index of 16-18
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